

A Thesis Submitted for the Degree of PhD at the University of Warwick

Permanent WRAP URL:

<http://wrap.warwick.ac.uk/146278>

**Copyright and reuse:**

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it.

Our policy information is available from the repository home page.

For more information, please contact the WRAP Team at: [wrap@warwick.ac.uk](mailto:wrap@warwick.ac.uk)

# **Experiences of Fatherhood**

Emma Jayne Dandy, MSc BSc

This thesis is submitted in partial fulfilment of the requirements for the degree of  
Doctorate in Clinical Psychology

**Coventry University, Faculty of Health and Life Sciences**  
**University of Warwick, Department of Psychology**

**May 2019**

## Table of Contents

Table of Contents.....	ii
List of Tables and Figures.....	vi
List of Abbreviations .....	vii
List of Appendices .....	viii
Acknowledgements.....	ix
Declaration .....	x
Summary .....	xi
<b>Chapter I: Fathers’ Experiences of Mental Health Difficulties in the Perinatal Period: A Meta-Ethnographic Review .....</b>	<b>1</b>
Abstract .....	2
Introduction .....	3
Paternal Mental Health in Context .....	3
Systemic Impact of Paternal Mental Health Difficulties .....	5
Findings from Previous Literature .....	6
Rationale for Current Review .....	7
Aims and Objectives .....	8
Method .....	8
Systematic Literature Search .....	8
Search Terms .....	9
Search Strategy .....	12
Inclusion and Exclusion Criteria .....	12

Classification of Studies .....	14
Quality Assessment .....	15
Analytic Review Strategy .....	17
Reflexivity .....	19
Characteristics of Studies .....	19
Findings.....	32
Self-identity .....	34
Identity Confusion: “Once the baby is born you come third” .....	34
Identity Conflict: “There’s still a lot of old school thought” .....	37
Identity Strain: Work vs. Home .....	38
Help-Seeking.....	39
Barriers to Help: “We’re supposed to be able to get on with it” ....	39
Negative Formal Support: “I wouldn’t have a clue” .....	41
Positive Informal Support: “It’s all done over a beer and a few jokes” .....	42
Discussion .....	44
Summary of Findings .....	44
Clinical Implications .....	48
Strengths and Limitations .....	51
Directions for Future Research .....	53
Conclusion.....	55
References .....	56
 <b>Chapter II: “Mad, Sad and Bad” to Dad: Male Care-Leavers Experiences of Fatherhood .....</b>	 <b>70</b>

Abstract .....	71
Introduction .....	72
The Impact of Care Experience on Fatherhood .....	73
Previous Literature .....	74
Rationale for Study.....	75
Study Aims.....	76
Method .....	76
Research Design .....	76
Interpretative Phenomenological Analysis .....	77
Sampling Design and Recruitment .....	78
Interview Schedule .....	81
Data Collection.....	81
Description of Participants.....	83
Data Analysis .....	83
Validation Checks and Reflexivity.....	84
Ethical Considerations .....	85
Findings.....	86
Main Findings .....	86
Going Back to Move Forward .....	87
“Mad, Sad and Bad” .....	88
“I learned to be guarded” .....	90
“All that I wanted to achieve in life was normality” .....	92
Reliving the Past .....	93
“Eyes are always on me” .....	93
“It’s like me being a kid again” .....	98

Breaking the Cycle .....	99
“I can see what I don’t want to be” .....	99
“It’s the one thing I’ve done right” .....	101
“I’ve found my place” .....	102
Discussion .....	104
Clinical Implications .....	107
Limitations and Directions for Future Research .....	110
Conclusion .....	113
References .....	114
<b>Chapter III: Not Knowing and Not Belonging: A Reflective Account of the Research Process.....</b>	<b>124</b>
Introduction .....	125
Reflexivity .....	125
Not Knowing, Not Belonging: My Research Position.....	126
‘Ghosts’ in the Research .....	131
‘Hard to Reach’ or Socially Excluded?.....	133
Conclusion.....	136
References .....	137
<b>Appendices .....</b>	<b>140</b>

## **List of Tables**

### **Chapter I: Systematic Literature Review**

Table 1. Key Search Terms .....	11
Table 2. Inclusion and Exclusion Criteria.....	12
Table 3. Stages of Meta-Ethnography (Noblit & Hare, 1988) .....	18
Table 4. Characteristics of Reviewed Studies .....	21
Table 5. Main Themes and Subthemes .....	32
Table 6. Contributions of Studies to Main Themes and Subthemes.....	33

### **Chapter II: Empirical Research**

Table 1. Inclusion and Exclusion Criteria.....	79
Table 2. Participant Demographics.....	83
Table 3. Superordinate and Subordinate Themes .....	87

## **List of Figures**

### **Chapter I: Systematic Literature Review**

Figure 1. PRISMA Flow Diagram.....	15
------------------------------------	----

## **List of Abbreviations**

### **Chapter I: Systematic Literature Review**

<b>MH</b>	Mental Health
<b>PMH</b>	Perinatal Mental Health
<b>SPL</b>	Shared Parental Leave
<b>UK</b>	United Kingdom

### **Chapter II: Empirical Paper**

<b>MH</b>	Mental Health
<b>LAC</b>	Local Authority Care
<b>NAO</b>	National Audit Office
<b>IPA</b>	Interpretive Phenomenological Analysis

### **Chapter III: Reflective Paper**

<b>IPA</b>	Interpretive Phenomenological Analysis
------------	--



## **List of Appendices**

<b>A</b>	Author Guidelines for Journal of Reproductive and Infant Psychology.....	140
<b>B</b>	Blank Quality Assessment (Kmet, Lee & Cook, 2004).....	142
<b>C</b>	Systematic Review Quality Assessment Scores .....	143
<b>D</b>	Systematic Review Quality Assessment Scores: Independent Ratings .....	144
<b>E</b>	Extract of Data Analysis: Systematic Review .....	145
<b>F</b>	Certificate of Ethical Approval for Systematic Review .....	146
<b>G</b>	Author Guidelines for British Journal of Psychology .....	147
<b>H</b>	Participant Information Sheet, Consent Form and Debrief Sheet .....	149
<b>I</b>	Interview Schedule for Empirical Research .....	154
<b>J</b>	Pre-interview script and Demographic Information Sheet .....	155
<b>K</b>	Example of Coded Transcript: Empirical Research .....	156
<b>L</b>	Photograph of Visual Map of Themes for Empirical Research .....	158
<b>M</b>	Response from Respondent Validation .....	159
<b>N</b>	Independent Transcript Coding: Empirical Research .....	160
<b>O</b>	Certificate of Ethical Approval for Empirical Research .....	161

## **Acknowledgements**

Firstly, I would like to thank the fathers who took the time to participate – without their openness and honesty this research would not have been possible.

I would also like to acknowledge my research team, Jacky and Flick. Thank you for all of the support and encouragement you have provided over the duration of this project. I have been in awe of your knowledge and expertise and it has been a pleasure working with you both.

To my amazing family and friends, especially my mum, Vernesta, my dad, Bruce, and sister, Hannah. I can't begin to thank you all enough for always being there for me, for supporting me throughout everything and always being there with a cup of tea, a slice of cake and words of encouragement.

To my incredible fiancé, John-Paul, I will never be able to thank you enough for the endless love and support you have shown me over the last 15 years. You have been my rock throughout this whole process, and I couldn't have done it without you – we can start planning our wedding now!

Finally, I would like to thank 'Team Coventry 2016'. It has been a pleasure to share this experience with the most wonderful, intelligent ladies, who have managed to keep me laughing constantly over the past three years. Thank you all for making this so much fun!

## **Declaration**

This thesis has not been submitted for any other degree or to any other institution.

This thesis was completed under the academic and clinical supervision of Jacqueline Knibbs (Clinical Psychologist, Coventry University), Dr Felicity Gilbey (Clinical Psychologist, Northamptonshire NHS Trust) and Dr Anthony Colombo (Research Director, Coventry University), who supported with the initial formulation of ideas and research design. All of the material presented is my own work.

The systematic literature review is written for submission within the *Journal of Reproductive and Infant Psychology*. The empirical research paper is written in accordance with guidelines for publication within the *British Journal of Psychology*.

## Summary

Becoming a father is a significant life event for most men. Transition and adjustment to fatherhood can pose a number of challenges to fathers. There have been recent changes within UK government legislation which have encouraged increased paternity leave and research has recognised that the involvement of fathers in childrearing is beneficial for both parental mental health and child development. However, the research exploring fathers' experiences is limited, particularly when fathers have experienced mental health difficulties or adverse childhood experiences. This thesis focuses on fathers' experiences of parenthood in two distinct contexts: during the perinatal period (defined as pregnancy to one year post-natal) and when fathers have care-experience in childhood.

Chapter one presents a meta-ethnographic review of recent qualitative literature exploring fathers' experiences of mental health difficulties during the perinatal period. Following a systematic search of relevant databases and manual searching, fifteen research papers were identified and synthesised within the review. Findings from the review highlight the need for healthcare services to promote awareness of paternal perinatal mental health difficulties and to develop father-specific resources and support.

Chapter two is a qualitative study that explores care-experienced fathers' experiences of parenthood. Using an Interpretative Phenomenological Analysis (IPA) framework, it provides a detailed exploration of how care-experienced fathers make sense of parenting and how this is impacted upon by their early childhood. Implications for clinical policy and practice are discussed and recommendations for future research are considered.

Chapter three provides a reflective account of the research process from the perspective of the researcher. It considers the importance of reflexivity in qualitative research and reflects on the positionality of the researcher.

**Total word count at time of submission: 19, 032**

## **Chapter I: Systematic Literature Review**

### **Fathers' Experiences of Mental Health Difficulties during the Perinatal Period: A Meta-Ethnographic Review**

Chapter Word Count at Time of Submission: 7, 954  
(excluding abstract, tables, figures and references)

Formatted for publication within the *Journal of Reproductive and Infant Psychology*  
(see Appendix A for submission guidelines)

## Abstract

**Aim:** This review aimed to synthesise qualitative research exploring fathers' experiences of mental health difficulties during the perinatal period (pregnancy to one year postnatal). The transition to fatherhood can be challenging and has been shown to impact upon fathers' mental health and wellbeing. The mental health of fathers correlates with that of mothers as well as long-term outcomes for their children. In recent years there has been an increase in qualitative research exploring fathers' experiences of pregnancy, transition to fatherhood and postnatal experiences, however, systematic reviews of this literature are limited. **Method:** Using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, relevant databases (PsychINFO, Academic Search Complete, Medline, CINAHL and Web of Science) were systematically searched and 15 qualitative studies were identified. A meta-ethnographic approach translated existing findings to review fathers' perinatal mental health experiences. **Findings:** Two overarching themes emerged: 1) Self-Identity – encompassing Identity Confusion, Identity Conflict and Identity Strain, and 2) Help-Seeking – Barriers to Help, Negative Experiences of Formal Support and Positive Experiences of Informal Support. **Conclusion:** Fathers are vulnerable to perinatal mental health difficulties because of challenges to their self-identity. When support is needed barriers exist including help-seeking stigma and lack of father-specific resources. Fathers, therefore, rely predominately on informal support. Based on the synthesised findings, recommendations for future research and implications for healthcare professionals are discussed.

**Keywords:** *Perinatal, Fathers, Mental Health, Experiences, Review*

## **Introduction**

### ***Paternal Mental Health in Context***

This review focuses on fathers' mental health (MH) difficulties during the perinatal period. The term 'mental health' considers psychological, social and emotional wellbeing, whereby individuals feel able to manage daily stressors, contribute meaningfully to their community and feel connected to those around them (Department of Health, 2011; World Health Organisation, 2005). Perinatal mental health (PMH) difficulties are defined as difficulties impacting upon mental wellbeing occurring in the period throughout pregnancy to one year after childbirth (NICE, 2014). For the purposes of this review, fathers are defined as the biological parent of one or more children.

The transition to parenthood has been described as a challenging, stressful life event for both parents, characterised by sleep deprivation and changes in role and family dynamics (Nyström & Öhrling, 2004; Cowan & Cowan, 2000). Maternal PMH difficulties are well documented (see Nilni, Mehralizade, Mayer & Milanovic 2018 for recent review), however, paternal PMH is less well understood (Wong et al., 2016). There is increasing recognition that the psychosocial factors that make mothers vulnerable (e.g. reduced sleep, lack of social support) also impact on fathers (Philpott & Corcoran, 2018). Biological factors, such as changes in testosterone and vasopressin levels (Wynne-Edwards, 2001) may also contribute to mental health difficulties for fathers in the perinatal period. The prevalence of anxiety in new fathers is approximately 5-15%, respectively (Leach, Poyser, Cooklin & Giallo., 2016). The consequences of perinatal mental health difficulties for fathers can be severe. There is an increased risk of suicidality in those fathers experiencing

postnatal depression than in the general population (Quevedo et al., 2011). Furthermore, increased fatigue, stress and difficulties meeting the competing demands of work and home impact on fathers' wellbeing and mental health (Kamalifard et al., 2014). Perinatal mental health difficulties also impact upon the father-child relationship through reduced sensitivity and increased hostility towards their children, as well as decreases in marital satisfaction (Wilson & Durbin, 2010).

Globally, the rates of paternal postnatal depression vary considerably, from 1.2% in Ireland to 11.9% in Brazil (Kim & Swain, 2007). The causes of this variation may be multi-faceted, including use of different assessment tools (Kim & Swain, 2007), as well as cross-cultural differences in diagnosis and recognition of paternal mental health difficulties (Halbreich & Karkun, 2006). Countries that promote longer paternity leave and provide supportive, flexible working environments for fathers have been shown to decrease PMH difficulties (Cooklin et al., 2015). The importance of fathers' involvement throughout the perinatal period is being increasingly acknowledged at a wider policy level in the United Kingdom (UK). In 2015, the Shared Parental Leave (SPL) scheme was introduced allowing parents to share up to 52 weeks leave. It is estimated that only 2% of eligible parents have utilised the scheme, however, with the main barriers cited as financial, as fathers often earn more than mothers (Twamley & Schober, 2019). A short (typically 2 week) period of parental leave for the majority of fathers, as well as societal pressures to be actively involved in caregiving, add further demands on fathers living in the UK which may impact on their MH. In addition, there are currently no targeted PMH services available in the UK for fathers and no guidelines for the assessment of paternal MH difficulties by healthcare professionals (Oldfield & Carr,



2017). Thus, the importance of father involvement in childrearing and the impact of paternal MH on children is not fully recognised within UK legislation. Ultimately, this lack of recognition incurs considerable costs to the UK economy through time off work and use of NHS resources (Bauer, Parsonage, Knapp, Iemmi & Adelaja, 2014). It is clear, therefore, that paternal MH is a key public health issue and an important area of research.

### ***Systemic Impact of Paternal Mental Health Difficulties***

Adjustment to parenthood can impact upon the development of the parent-child relationship, which subsequently predicts long-term behavioural, emotional and cognitive outcomes for children (Ramchandani et al., 2008). Maternal MH is the strongest predictor of paternal MH, with 24-50% of fathers whose partners are experiencing postpartum depression also experiencing symptoms of depression (Goodman, 2004b). However, even after controlling for maternal MH, paternal MH difficulties significantly correlate with increased infant crying, poor school attainment and increased risk of oppositional and conduct disorders in childhood (Gentile & Fusco, 2017; Ramchandani, Stein, Evans & O'Connor, 2005; Sweeney & MacBeth, 2016). Furthermore, when both parents experience depression, children receive more negative parent-child interactions, resulting in poorer developmental outcomes (Paulson, Dauber & Leiferman, 2006). Thus, research suggests that fathers' wellbeing is associated with mothers' wellbeing and vice versa, in addition to influencing positive outcomes for children. As such, the mental health and wellbeing of fathers is vital to the wellbeing of the whole family. By providing appropriate support for fathers experiencing MH difficulties, outcomes for families can be improved (Office for National Statistics, 2016).

### *Findings from Previous Literature*

Whilst there is increasing recognition of paternal PMH difficulties and more qualitative literature exploring fathers' perinatal experiences is emerging, systematic reviews of this field are limited. The only existing review of fathers' experiences of PMH difficulties (Baldwin, Malone, Sandall & Bick, 2018) focused on first-time fathers. Baldwin et al. (2018) identified 22 papers published between 1990 and 2017 and used an aggregative method to synthesise the qualitative findings. They concluded that fathers experienced challenges in forming an identity, as well as managing the competing demands of fatherhood. In addition to Baldwin's et al. (2018) review, there is an emerging body of literature exploring subsequent fathers' MH experiences as well as a recognition of the relationship between maternal and paternal MH.

Existing reviews focusing on fathers' experiences of pregnancy (Kowlessar, Fox & Wittkowski, 2015), child-birth (Poh, Koh & He, 2014) and the transition to fatherhood (Chin, Hall & Daiches, 2011) have all contributed to a greater understanding of fatherhood experience. Chin et al. (2011) completed a meta-ethnographic review of six studies, published between 2002 and 2008, to explore fathers' adjustment to parenthood. The authors reported three key themes; Emotional reactions to transition; Identifying their role and Redefining the self and relationship with their partner. The findings highlighted that during the postnatal period fathers felt detached due to the impact of fatherhood on their identity and perceived change in role within the family. Fathers reported feeling excluded from the mother-child relationship which affected their ability to bond with their baby contributing further to feelings of inadequacy and distress.

Building upon Chin et al.'s (2011) findings, Kowlessar et al. (2015) conducted a meta-synthesis exploring first-time fathers' experiences of pregnancy. They reviewed 13 papers, published between 1982 and 2012, and concluded that to effectively support partners, expectant fathers needed to feel valued and be encouraged by professionals to be involved throughout pregnancy. Although Chin et al. (2011) and Kowlessar et al. (2015) explored fathers' experiences at different stages of the perinatal period, there were commonalities in fathers' feelings of exclusion by healthcare services and within the family. Further reviews have explored fathers' views of maternity care services and concluded that fathers feel themselves to be 'partner and parent' but their experience of maternity services is as "*not-patient and not-visitor*" (Steen, Downe, Bamford & Edozien, 2011, p. 422). This study concluded that fathers feel fearful throughout pregnancy and labour, but are excluded from maternity services, resulting in distress and confusion relating to their role.

### ***Rationale for the Current Review***

There is an emerging body of qualitative literature exploring fathers' experiences of PMH difficulties, which has provided some in-depth and rich understanding of fatherhood. However, a systematic review of this literature is notably limited. Although, one review has been completed (Baldwin et al., 2018), it was limited by its narrow remit of exploring first-time fatherhood only, thereby neglecting fathers with more than one child. Second-time parents display higher rates of depression and anxiety than first-time parents (Figueiredo & Conde, 2011) and much of the literature includes both first and subsequent fathers. To date there has been no

critical review of this research meaning that our understanding of this issue remains less coherent. By systematically reviewing the international literature regarding both first-time and subsequent fathers' PMH experiences, an increased understanding of how to support fathers experiencing MH difficulties in the perinatal period can be gained, positively impacting on partner and child, as well as fathers. This will begin to provide insights to improve the perinatal mental health and well-being of fathers in the UK.

### ***Aims and Objectives***

This review sought to broaden recent findings by Baldwin et al. (2018) to include all fathers and systematically synthesise the qualitative research to explore the question: *What are fathers' experiences of mental health difficulties during the perinatal period?*

## **Method**

### ***Systematic Literature Search***

A systematic search for studies that explored fathers' experiences of MH difficulties during the perinatal period was carried out between April 2018 and December 2018. Ethical approval for the review was granted by Coventry University (Appendix F). As the research question centred around exploring fathers' experiences, the review focused on qualitative literature, including the qualitative aspects of mixed methods research. A meta-ethnographic approach (Noblit & Hare, 1988) was selected over a thematic synthesis approach (Thomas & Harden, 2008) due to its common use within health research (Hannes & Macaitis, 2012). A meta-ethnographic review is a

specific type of meta-synthesis defined by the translation of themes from individual studies into overarching concepts and higher order interpretations. The objective of meta-ethnography is to produce an enhanced understanding of a topic (Doyle, 2003). Further, its interpretative epistemological stance considers the context of the research to be important as participants' meaning is central within qualitative research (Pope, Mays & Popay, 2007). It is recommended that researchers select a method of review that "*best fits their view of research epistemology*" (Paterson, 2012, p. 10). The systematic search was conducted in accordance with the 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' (PRISMA) method (Moher, Liberati, Tetzlaff, & Altman, 2009), see Figure 1. A robust systematic search of the literature within PsychINFO, Academic Search Complete, Medline, CINAHL (provided through EBSCOhost) and Web of Science databases was completed, as these databases are most relevant to the topic area and have been identified by similar systematic reviews in the field (Chin et al., 2011; Kowlessar et al., 2015; Rominov, Pilkington, Giallo & Whelan, 2016). In addition, Walsh and Downe (2006) recommended that further manual searching is required to capture qualitative research that may be missed by traditional meta-analytic search strategies. Therefore, references and citation lists of all selected articles were checked (Barroso et al., 2003). Grey literature was not included as it does not fit the inclusion criteria of being peer-reviewed.

### ***Search Terms***

Key search terms and synonyms were identified through examination of relevant previous literature. The identified terms included the key concepts: father, perinatal,

mental health and qualitative, in addition to synonyms, and were located within titles or abstracts (Table 1). The term ‘father’ encompassed non-biological fathers, such as step-fathers and adoptive fathers, as well as those fathers who did not live with their children.

Table 1. Key Search Terms

Key Concept	Synonym	Location
Father	Dad	Title
	Male	Abstract
	Men	
	Paternal	
Perinatal	Pregnancy	Title
	Antenatal	Abstract
	Postnatal	
	Prenatal	
	Postpartum	
Mental health	Mental illness	Title
	Mental disorder	Abstract
	Psychiatric illness	
	Psychiatric disorder	
Qualitative	Experiences	Title
	Interpretative Phenomenological Analysis	Abstract
	IPA	
	Thematic Analysis	
	Content Analysis	
	Grounded Theory	
	Interview	

### ***Search Strategy***

Using Boolean search operators, the search strategy identified was ‘father\* or dad\* or paternal or male or men AND mental health or mental illness or mental disorder\* or psychiatric illness or psychiatric disorder\* AND perinatal or antenatal or postnatal or prenatal or postpartum or pregnancy AND qualitative or experience\* or interpretative phenomenological analysis or IPA or thematic analysis or content analysis or grounded theory or interview\*’.

### ***Inclusion and Exclusion Criteria***

Article titles and abstracts were initially screened and retained if they were i) written in English; ii) published in a peer-reviewed academic journal; iii) reported fathers’ experiences of MH difficulties during the perinatal period and iv) the full text was available. Following initial screening, full text articles were obtained and assessed for eligibility according to the inclusion criteria (Table 2). Studies were included if participants are i) fathers and ii) experienced emotional distress during the perinatal period.

Table 2. Inclusion and Exclusion Criteria

<b>Criteria</b>	<b>Include</b>	<b>Exclude</b>
Gender of Parent	Fathers OR Mothers and Fathers	Mothers only
Mental Health Difficulties	Participants accessed support for mental health difficulties for themselves or their partner	Support for parenting or social services support only with no mention of mental health distress



Support in Perinatal Period	Services accessed in perinatal period (from pregnancy to 1 year postnatal)	Support accessed before or after perinatal period
Childbirth	No major complications during childbirth	Studies on fathers experiencing bereavement following neonatal death, still birth, sudden infant death or traumatic childbirth
Relationship with Child	Biological fathers and non-biological fathers (such as step-fathers or adoptive fathers)	
Length of Pregnancy	Studies of fathers whose infants were born at full term or overdue (37+ weeks)	Studies of fathers whose infants are born prematurely (before 37 weeks)
Research Methodology	Studies using qualitative research methods or qualitative aspects within mixed methods	Studies using quantitative research methods only
Time Period	Published between 2008 and 2018	Published prior to 2008
Language	Written in English or English translation available	Non-English Language

---

As this is an emerging research area, no limits were placed on sample size, recruitment method or method of data collection. Studies that considered the impact

of maternal MH on paternal MH were included due to the relationship between these factors (Paulson & Bazemore, 2010). Studies of mothers and fathers were included if the experiences of fathers could be distinguished. To provide a recent review of the research, the search was limited to peer-reviewed academic journal articles published between 2008 and 2018 and written in English. Due to changes in attitudes towards fatherhood and gender roles over the past ten years (Doucet, 2009a) and the increasing recognition of the importance of fatherhood involvement (Ramchandani et al., 2008) excluding studies published prior to 2008 would allow findings to be relevant to current societal norms.

### *Classification of Studies*

The process of study selection is recorded on the PRISMA flow diagram (Moher et al., 2009), see Figure 1. A total of 1, 174 articles (PsychINFO  $n=199$ ; Academic Search Complete  $n=190$ ; Medline  $n=209$ ; CINAHL  $n=101$ ; Web of Science  $n=468$ ) were initially identified through database and manual searching, of which 514 were duplicates, resulting in 660 screened against the inclusion criteria. Full texts for 44 journal articles that met the initial criteria were reviewed and a further 29 were excluded due to not including the experiences of fathers, not exploring MH difficulties or not adequately distinguishing between the experiences of mothers and fathers. This resulted in 15 relevant studies, which satisfied the inclusion criteria; these were retained for quality assessment.

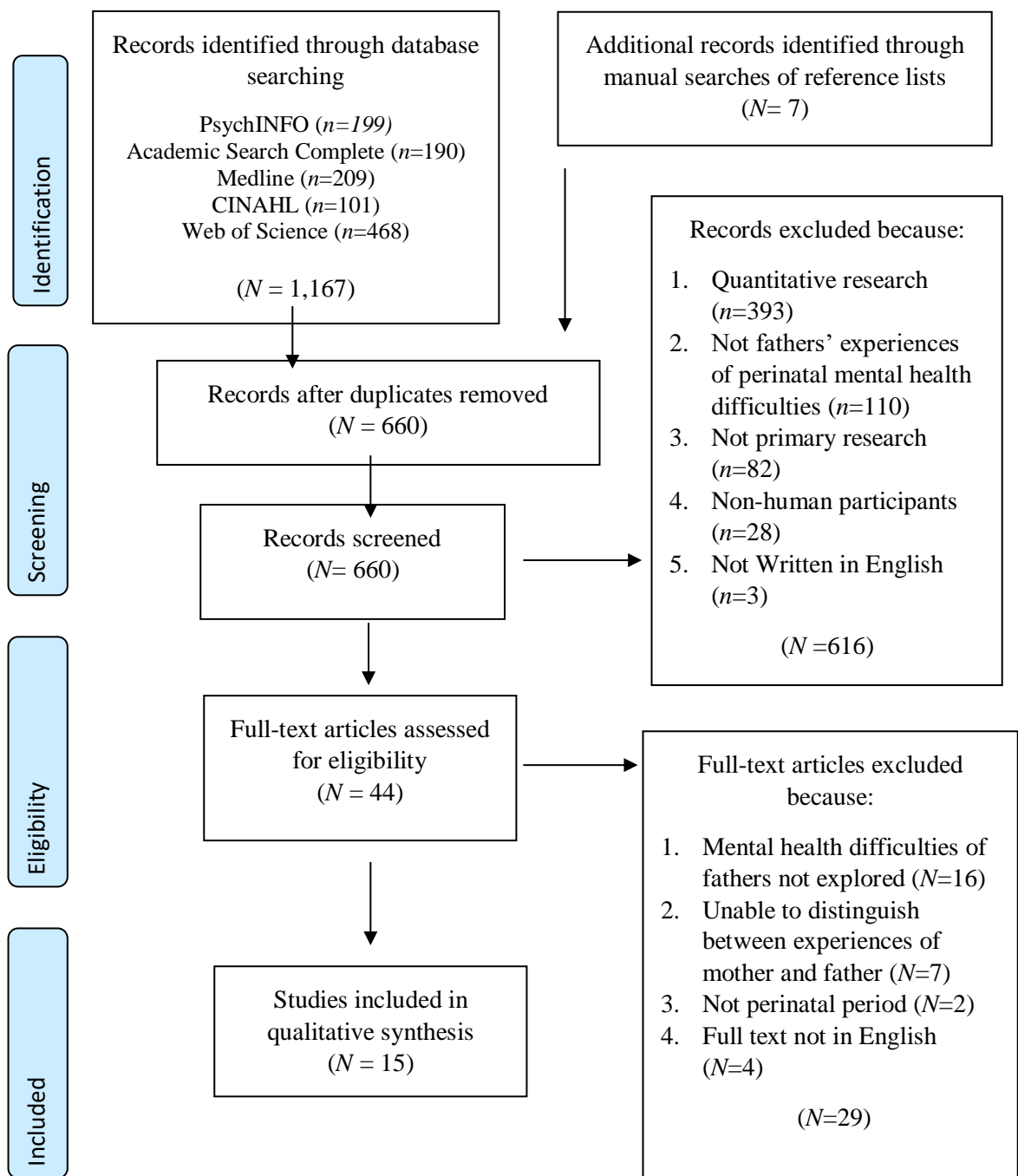


Figure 1. PRISMA Flow Diagram

### *Quality Assessment*

There is no agreed best practice instrument for assessing the quality of qualitative literature (Dixon-Woods et al., 2006). The Standard Quality Assessment Criteria

(Kmet, Lee & Cook, 2004) measure was selected as it is frequently used for systematic reviews within the PMH field (e.g. Ashford, Olander & Ayers, 2016) and provides a standardised scoring system for rating qualitative research articles. It is a 10-item validated instrument that assesses the rigour, credibility and relevance of qualitative research papers. There is some debate as to the utility of applying a scoring system to assess qualitative research as it is argued that this approach is contradictory to the interpretivist epistemology of qualitative research (Kuper, Lingard & Levinson, 2008). However, it is widely acknowledged that quality assessment is a key feature of robust, high-quality systematic reviews (Saini & Shlonsky, 2012). The current review will use the quality ratings as a guide to explore the strengths and limitations of the studies rather than as a definitive assessment tool.

All studies were scored against ten quality criteria (Appendix B). Studies were rated as zero if criteria were not met, one if criteria were partially met and two if the criteria were fully met (see Appendix C for detailed scores for each study). The rating for each article was calculated to provide a total score between zero and twenty. All articles scored between 15 and 20, above the midpoint score of 10, and were deemed to reach a satisfactory level of rigour in terms of the quality assessment framework (Kmet et al., 2004). The majority of studies ( $n=8$ ) received scores of 18-20 indicating high quality. All studies identified clear research objectives and at least partially met criteria related to appropriate study design, data collection and analysis. The most common reason for reduced scores was the absence of reflexivity.

The three lowest scoring papers (Doucet, Letourneau & Blackmore, 2012; Engqvist & Nilsson, 2011; Johansson, Edwardsson & Hildingsson, 2015) lost points as there was no evidence of validation checks or reflexivity within the study. It is possible that journal word limit constraints led to these aspects being excluded at publication. As these studies received scores above midpoint they were considered to be of high quality and retained for inclusion within the analysis. To further enhance the reliability of the quality assessment checks, a second researcher rated all articles against the same quality criteria (Appendix D). Inter-rater reliability analyses were performed using the Cohen's Kappa statistic ( $\kappa$ ) to provide a robust measure of the level of agreement between the researcher and the independent rater. Statistical analysis indicated a 'substantial' to 'almost perfect' level of inter-rater reliability (McHugh, 2012) with an overall score of  $\kappa = 0.81$ ,  $p < 0.001$ , ranging between  $\kappa = 0.62$  and  $\kappa = 1.0$  for each study (see Table 4). Eight studies achieved unanimous agreement between ratings. Where scores differed substantially researchers met to discuss scores and reached a consensus. From the quality assessment conducted, it can be concluded that all studies were of sufficiently high quality, therefore, contribute towards a methodologically robust systematic review (Walsh & Downe, 2006).

### ***Analytic Review Strategy***

Meta-ethnography aims to translate studies into one another in order to arrive at an interpretation greater than that offered by individual studies (Britten & Pope, 2011) and has been shown to be an effective method for synthesising qualitative research

(Campbell et al., 2011). Following Noblit and Hare's (1988) recommendations for conducting meta-ethnographic reviews, seven stages were followed (Table 3).

Table 3. Stages of Meta-Ethnography (Noblit & Hare, 1988)

Stage	Description
1	Identifying the area of interest
2	Selecting what is relevant to the initial area of interest (i.e. selecting the studies to be included)
3	Reading the studies
4	Determining how the studies are related
5	Translating the studies into one another
6	Synthesising the translations through identification of similar concepts
7	Expressing the synthesis in a written format

Atkins et al. (2008) acknowledged weaknesses with Noblit and Hare's (1988) approach as some stages are poorly defined and require further explanation. Therefore, throughout steps 4 to 6, recommendations by Atkins et al. (2008) were used to guide the synthesis of studies. Key phrases and concepts within each research article were organised into grid format to display main concepts and themes. Following this, concepts and themes were compared using "*reciprocal translation*" (Atkins et al., 2008, p.7) in which themes from study 1 and 2 were combined and compared to study 3. The themes from these three studies were then compared to study 4 and so on. For inclusion within the review, findings needed to be present in more than one study. To synthesise findings, Atkins et al. (2008) reported a method of moving from reciprocal translation to higher order interpretation to create an

overarching model that combines translations and author interpretations (see Appendix E for extract of data analysis). To promote reflexivity, translations extracted by the main author were discussed with the research team to reduce the impact of personal bias.

### ***Reflexivity***

In qualitative research it is important to embed reflexivity throughout to ensure that the impact of personal assumptions on the interpretation of findings is acknowledged (Shaw, 2010). In the case of this review, the main author is a Clinical Psychology trainee with an interest in perinatal mental health. Through discussions with the research team and documenting personal reflections, the author's assumptions were recognised. Based on prior clinical experience, the main author acknowledged a bias towards findings related to help-seeking stigma in fathers and fathers feeling excluded from maternity services. In order to address this potential bias, the research team held in mind positive help-seeking behaviours to ensure that the subsequent findings were balanced and accurately reflected the findings of the included studies. Throughout the review process, the author was also engaged in research with care-experienced fathers. These research topics provided the author with the view that fathers in general were often overlooked in research focusing on parenting.

### ***Characteristics of Studies***

As can be seen in Table 4, 15 eligible studies were included in the review. The studies included a total of 1,937 participants, of whom 1,889 were fathers, aged 19 to 52 years. Eleven studies discriminated between first-time and subsequent fathers, identifying 841 first-time fathers and 933 subsequent fathers. Despite the inclusion

criteria of non-biological and biological fathers, all fathers within the identified studies were in heterosexual relationships and were biological parents. Eight studies focused on the experiences of fathers' PMH difficulties, with four also exploring the support needs of fathers. Two studies specifically explored barriers to support for fathers experiencing PMH difficulties; five studies focused on the impact of partners' MH (including postnatal depression and postpartum psychosis) on fathers' emotional wellbeing. Nine of the studies were conducted within the last five years (2013-2018) and all were completed within Western cultures (Australia, Canada, USA, UK and Sweden).

Twelve studies employed thematic or content analysis, whilst two studies used IPA and one grounded theory to analysis data. Although assessed to be of sufficient quality, it should be noted that Dallos and Nokes' (2011) findings were based on data from only one participant, however, authors used IPA methodology to elicit in-depth insights into the father's experiences and, therefore, was retained for analysis. Johansson, Thomas, Hildingsson and Haines (2016) and Johansson et al. (2015) both utilised survey designs to gather qualitative data which presented limited direct quotes within the articles, however, again presented with sufficient quality for retention.



Table 4. Characteristics of Reviewed Studies

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
Boddy, R. Gordon, C. MacCallum, F. McGuinness, M.  2016  UK	To explore the experiences of men during their partner's admission to MBU for first episode postpartum psychosis	Qualitative  Purposive sampling	<i>n</i> =7  Men whose partner was under the care of Mother and Baby Unit for first episode postpartum psychosis.  Age range 23-42.  First-time fathers ( <i>n</i> =6); Subsequent fathers ( <i>n</i> =1). Married/Engaged ( <i>n</i> =5); Co-habiting ( <i>n</i> =1); Other ( <i>n</i> =1).	Face to face, semi-structured interviews conducted in MBU clinic rooms.  Interviews lasted 40-84 minutes.	Interpretative Phenomenological Analysis (IPA)	Two Superordinate themes: 1. <i>What the F** is going on?</i> Reflected the participants' lack of understanding during the onset and treatment. 2. <i>Time to figure out how your family works</i> Postpartum Psychosis impacted on roles, relationships and identity of partners.  Five Subordinate themes: 1a. Postpartum psychosis as an unexpected arrival 1b. Not feeling heard 2a. Holding the fort 2b. Loss and reconnection 2c. Adjusting to family life	QR=20 ( $\kappa$ =1.0)

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
Dallos, R Nokes, L.  2011  Plymouth, UK	To explore the experiences of first-time fathers who were encountering psychological difficulties following the birth of a baby.	Qualitative  Purposive Sampling  Recruited via parenting group in an urban environment	$n=1$  First-time father aged 40 years. Child age 5 months at time of interview.	Semi-structured interview based on five broad areas; Changes since the birth of the baby, experience of becoming a father, influence of birth on relationships, understanding of current difficulties and experience of difficulties as a man.	IPA (Smith, Jarman & Osbourne, 1999)	Identified two superordinate themes: 1. <i>Loss</i> – experience of grief and sadness at loss of partner relationship since birth of child; 2. <i>Difficulties with adjustment</i> – struggle with identity of being a father and wanting to fulfil ideal father role.	QR=20 ( $\kappa=1.0$ )
Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., Gilbody, S.  2017  Yorkshire, UK	To examine the views and experiences of fathers reporting psychological distress concerning their perinatal mental health. To explore their perceptions of what makes support services accessible and acceptable.	Qualitative  Participants purposively sampled from Born and Bred in Yorkshire (BaBY) cohort. Parents recruited via maternity services across North	$n=19$  First-time fathers ( $n=14$ ); Subsequent fathers ( $n=5$ ).  Aged 25-44 years ( $M=33.1$ years).	Semi-structured interviews following interview guide.  Fifteen interviews conducted face-to-face, and four telephone interviews.  Interviews ranged from 18 to 83 mins.	Thematic analysis approach (Braun & Clarke, 2006)	Four main themes: 1. <i>Legitimacy of paternal stress and entitlement to support from professionals</i> – fathers accepted the existence of paternal stress but often questioned their entitlement to these feelings; 2. <i>Protecting the partnership</i> – Fathers emphasised the need to protect their partner and their relationship and recognised changes in their relationship;	QR=19 ( $\kappa=0.62$ )

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating ( <i>QR</i> ) (Reliability co-efficient)
		Yorkshire and East Lincolnshire in 2011-14.				3. <i>Navigating fatherhood</i> – men preferred to talk about what ‘worked’ in managing stress; 4. <i>Diversity of men's support networks</i> – diversity of support networks available for fathers, however, there was a lack of tailored resources.	
Doucet, S., Letourneau, N., Blackmore, E. R. 2012 Canada and USA	To explore the support needs, preferences, accessibility of resources and barriers to support to women and their partners affected by postpartum psychosis.	Qualitative  Purposive Sampling	<i>n</i> =17 couples (Mothers <i>n</i> =9; Fathers <i>n</i> =8) First-time mothers ( <i>n</i> =6); Subsequent mothers ( <i>n</i> =3). Not stated in study whether fathers had other children.	Individual, semi-structured interviews over the telephone or face-to-face.  Lasted between 45-120 minutes. Partners interviewed separately.	Thematic Analysis	Main themes for Fathers: 1. <i>Support Needs</i> – to support partner; to support themselves. 2. <i>Support Preferences</i> – Informational support from professionals; Instrumental support from informal network. 3. <i>Accessibility of Support</i> – Limited professional support; Limited community support; Family provided the majority of support. 4. <i>Barriers to Support</i> – Health service barriers; Personal barriers.	<i>QR</i> =16 ( $\kappa$ =0.75)
Edhborg, M., Carlberg, M., Simon, F., Lindberg, L.	To describe fathers' experiences of the first year	Qualitative  Purposive Sampling	<i>n</i> =19	Semi-structured interviews based on an interview schedule.	Content Analysis (Graneheim &	One main theme: <i>Loss of control and Powerlessness</i> – a lack of knowledge and feelings of	<i>QR</i> =18 ( $\kappa$ =1.0)

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
2016 Stockholm, Sweden	postpartum, when they showed depressive symptoms 3 to 6 months postpartum.		First-time fathers ( $n=9$ ), subsequent fathers ( $n=10$ ).  Aged 25-52 years ( $M=36$ years).  Fathers scored 10+ on Edinburgh Postnatal Depression Scale.  Purposive sampling from a larger quantitative study.	All interviews conducted face-to-face.  Interviews lasted approximately 60 minutes.	Lundman, 2004).	uncertainty resulted in fathers feeling isolated, trapped and alone which impacted on the relationship with their partner.  Loss and Powerlessness was outlined by five categories: 1. Discrepancies between expectations and reality after birth. 2. Turbulent everyday life with parental stress and lack of support; 3. Changes in the partner relationship; 4. Negative life events and sense of loss; 5. Contradictory messages from society and their partner.	
Engqvist, I. Nilsson, K. 2011 Sweden	To explore men's experience of having a partner with Postpartum Psychiatric Disorders (PPPD)	Qualitative  Purposive sampling	$n=11$  Men with spouse or partner with a postpartum psychiatric illness.  Age ranges not described.  Number of children not stated in study.	11 written narratives from the internet. Found through search engines (Google, Alta-Vista and Yahoo).  Narratives ranged from 208-3507 words.	Analysed using content analysis.	Five Main Themes: 1. <i>Days filled with stressful events</i> – Partners felt disappointed and frustrated in the initial part of the illness which was related to difficulties in understanding the diagnosis; 2. <i>Continued interference with everyday life</i> – The continuous fluctuation in their partners condition dominates the men's lives;	QR=15 ( $\kappa=0.75$ )

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating ( <i>QR</i> ) (Reliability co-efficient)
						<p>3. <i>Acceptance of reality and finding solutions</i> – Fathers' identified feelings of acceptance of their partner's diagnosis and described hope for future;</p> <p>4. <i>Life starts to return</i> – Their partner's illness and life situation becomes manageable;</p> <p>5. <i>Coping with the past</i> – Men described positive aspects of their experience and describe what they have learned.</p>	
Gervais, C. de Montigny, F. Lacharité, C. St-Arneault, K.  2016  Quebec, Canada	Where do fathers fit within the observations, concerns and actions of the perinatal health care providers, according to parents' perceptions and the analysis of institutional documents. What are fathers' needs for services and formal support during the perinatal period?	Qualitative  Participants recruited using purposive sampling as part of wider study	<p>17 couples, new or expectant parents</p> <p>Age of father = 22-46 years (<math>M=34</math> years)</p> <p>Age of mother = 18-40 (<math>M=32.2</math> years).</p> <p>Number of children: 1 to 5 (<math>M=2.29</math>).</p> <p>Age of children = prenatal to 24 months</p>	<p>Semi-structured interview, face to face.</p> <p>Couples interviewed together to better understand mothers' perception of fathers as well as fathers' experiences.</p>	Thematic Analysis (Paillé & Mucchielli, 2012)	<p>Three main themes:</p> <p>1. <i>Fathers place in the conjugal relationship</i> – Fathers felt a duty to support their partner;</p> <p>2. <i>Fathers place in relation to health care providers</i> – Fathers described a continuum of care from feeling welcomed within maternity and healthcare settings to feeling excluded from services;</p> <p>3. <i>Fathers place in services (feeling excluded)</i> – Fathers felt that there was little space for them in services.</p>	$QR=18$ ( $\kappa=1.0$ )

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
Johansson, M. Edwardsson, C., Hildingsson, I.  2015  Sweden	To describe how expectant fathers experienced physical and emotional changes, the prevalence of the changes, and whether the sensations changed over time.	Mixed Methods – Qualitative survey design  Purposive Sampling	$n=871$  Expectant Fathers  First-time fathers ( $n=410$ ), Repeat fathers ( $n=461$ ).	Longitudinal mixed methods approach. Data collected through questionnaires.	Qualitative data analysed using content analysis.	Three main themes highlighted the impact of pregnancy on expectant fathers: 1. <i>Positive impact on Mental Health</i> – Expectant fathers described the positive impact of pregnancy on their MH including feelings of delight, pleasure and emotional balance; 2. <i>Negative impact on Mental Health</i> – Expectant fathers also reported that pregnancy led to anxiety, fear and panic about partner and baby's wellbeing; 3. <i>Emotional relationship developed with partner and baby</i> – Expectant fathers reported decreased contact with partner and decreased love and tenderness.	QR=15 ( $\kappa=0.75$ )
Johansson, M. Thomas, J., Hildingsson, I., Haines, H.  2016  Sweden	To explore fathers concerns about parenting 2 months after the birth of their baby.	Mixed Methods – Qualitative survey design  Purposive Sampling	$n=827$  First-time fathers ( $n=368$ ); Fathers with other children ( $n=424$ ).  Age ranges not provided.	Data collected from large prospective longitudinal study in 2007-8.  Completed questionnaires at four time points, from mid-	Content Analysis (Downe-Wambolt, 1992)	Overarching theme: <i>Managing the demands of being a father</i> – Fathers reflected on their concerns about being able to emotionally, physically and financially support their families.  This main theme consisted of two subthemes: 1. <i>Having responsibility as a father</i> - Getting the	QR=17 ( $\kappa=0.78$ )

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
				pregnancy to 2 months after birth.  Short responses to open-ended questions.		upbringing right and having enough money; 2. <i>Struggling for a state of equilibrium</i> - having enough time and navigating a new family pattern.	
Letourneau, N. Duffett-Leger, L. Dennis, C.L. Stewart, M. Tryphonopoulos, P.D.  2011  New Brunswick and Alberta, Canada	What are fathers' experiences of personal PPD? What are fathers' support needs and resources? What are the barriers to accessing support? What interventions do fathers prefer?	Qualitative  Convenience sampling method employed to recruit men whose partners reported symptoms of PPD during their last pregnancy. Less than 2 years post-partum.	$n=11$  First time fathers ( $n=6$ ), Subsequent fathers ( $n=5$ ).  Seven fathers from New Brunswick; Four fathers from Alberta.  Age range 29-44 years ( $M=37$ years).	Semi-structured interviews completed via telephone.  Interview guide consisted of 27 questions.  Interviews lasted 60-120 mins.	Thematic Content analysis.	Three main themes: 1. <i>Fathers' experiences of coping with partners' PPD</i> – Fathers experienced a range of emotions including anxiety, helplessness and anger during their partners admission to hospital; 2. <i>Support needs and resources of fathers and mothers</i> - Accessing information was important to fathers; 3. <i>Barriers to support for fathers</i> – Fathers described a lack of information and did not know where to get information which presented as the main barrier to help-seeking.	QR=18 ( $\kappa=1.0$ )
Letourneau, N. Panagiota, D. Tryphonopoulos, P.,	To describe the support needs and preferences of fathers whose partners have had PPD.	Qualitative  Purposive Sampling used.	$n=40$  Male partners of women who experienced PPD	Telephone interviews completed. Semi-structured interview guide consisting of 47	Thematic content analysis	Main Themes: 1. <i>Support needs</i> – Fathers explored the types of support that they would have found beneficial e.g. someone to talk to about their partner's diagnosis;	QR=17 ( $\kappa=0.76$ )

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
Duffett-Leger, L., Stewart, M., Benzies, K., Dennis, C-L., Joschko, J. 2012 Canada		Participants recruited through service providers, PPD support groups, social networking sites.	within the past 10 years.  Age 23-46 (Mean=37 years)  Married/Common Law ( $n=39$ )  Number of children not stated in study.  $n=16$ fathers reported experiencing depressive symptoms	questions relating to fathers' support needs, barriers and preferences.  Interviews lasted approx. 1.5 hours.		2. <i>Support preferences</i> – Fathers described how they wished to receive support e.g. professionals should be more proactive, and individual and group support was desired; 3. <i>Intervention agents</i> – Fathers reflected on who should provide support and posed arguments for both peer and professional support; 4. <i>Location of support</i> – Fathers favoured support at home rather than in community settings.	
Marrs, J., Cossar, J., Wroblewska, A. 2014 Scotland, UK	To investigate what impact a mother and baby unit admission had on the fathers' role and relationship with his family.	Qualitative  Purposive Sampling	$n=8$  First time fathers ( $n=5$ ); Subsequent fathers ( $n=3$ ).  Aged between 28-51 years ( $M=37.5$ ). 3 fathers interviewed during partners admission. 5 fathers interviewed post-discharge.	Individual interviews conducted. Lasted between 49 and 103 mins ( $M=69$ min). Open-ended, non-judgemental questions to allow participants' stories to emerge.	Grounded Theory methodology	Overarching Theme: <i>Managing the Self and Other Relationships</i> – This theme captures how fathers understand their experience and their role in making and maintaining bonds with their family.  This theme included five Subthemes: 1. <i>Bonding with Baby</i> – Importance of being with baby; Father needing to bond; A fleeting figure.	QR=17 ( $\kappa=0.63$ )



Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
						2. <i>Keeping the Family Together</i> – Relying on support from family and friends; Adjusting the couple relationship. 3. <i>Feeling Contained</i> – Admission provided relief to fathers as professionals could care for mother . 4. <i>Feeling Overwhelmed</i> – Experiencing anxiety and stress. 5. <i>Experiencing and Managing Uncertainty</i> – Understanding illness and treatment; Communicating with staff.	
Reid, H. Wieck, A. Matrunola, A. Wittkowski, A.  2016  Manchester, UK	To identify how fathers experience the mental illness of their partner, and how this impacted upon their relationship.  Secondly, to learn how fathers experienced the Mother and Baby Unit and whether they felt supported by Child and Family Services.	Qualitative  Purposive Sampling	<i>n</i> =17  First time fathers ( <i>n</i> =11); Subsequent fathers ( <i>n</i> =6). All biological fathers.  Married ( <i>n</i> =8); Co-habiting ( <i>n</i> =9) with mother  Fathers (over 18 years old) whose partner was admitted to a MBU in North West.	Face-to-face, semi-structured interviews, following interview schedule.  Interviews lasted 45 to 60 minutes.	Inductive thematic analysis (Braun & Clarke, 2006).	Four main themes: 1. <i>Double Whammy</i> – Fathers experienced a conflict between the needs of mother and baby; 2. <i>Understanding Admission and Illness</i> – Father described understanding and coming to terms with the mother's diagnosis; 3. <i>Support for fathers</i> – Fathers reported that support was either emotional or practical depending on service provider; 4. <i>Personal Stressors and Coping</i> – Fathers used a range of self-	QR=20 ( $\kappa$ =1.0)

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
						reliant coping strategies, both health and unhealthy.	
Rominov, H. Giallo, R. Pilkington, P.D, Whelan, T.A.  2017  Melbourne, Australia	What are expectant and new fathers' experiences around accessing resources and support for mental health and parenting? What are fathers' specific support needs during the perinatal period? What are the perceived barriers and facilitators to accessing support?	Qualitative  Convenience sample recruited via snowball sampling, using word of mouth and online advertising.	$n=20$  First-time fathers ( $n=5$ ); Parent expecting another child ( $n=7$ ); Parents of infant under 2yrs ( $n=8$ ).  Age range 30 to 42 ( $M=33.9$ years)	Semi-Structured interviews lasting 30 mins.  Face-to-face ( $n=4$ ) and telephone ( $n=16$ ) interviews.	Semantic Thematic Analysis	Five main themes: 1. <i>Experiences of support</i> – Marginalised from formal support and preference for informal support; 2. <i>Support needs</i> – Fathers wanted more preparation for fatherhood and information accessible in multiple formats; 3. <i>Barriers to support</i> – Stigma, and inflexible work arrangements were main barriers; 4. <i>Facilitators of support</i> – Fathers wanted to be included and expressed lack of awareness about how to get support; 5. <i>Timing of support</i> – Fathers identified varying support needs at different perinatal stages.	QR=20 ( $\kappa=1.0$ )
Rowe, H.J., Holton, S. Fisher, J.R.  2013  Melbourne, Australia	To investigate expectant parents' anticipated needs and preferred sources of support for emotional health during	Qualitative  Purposive sampling.  Participants recruited through	$n=38$  First-time pregnant women and their partners (22 women, 16 men). All heterosexual relationships.	Six small group discussions and five individual interviews following a discussion guide to elicit	Thematic analysis techniques (Green et al., 2007)	Three Main Themes: 1. <i>Imagining life and needs with a baby</i> – Fathers expressed excitement about becoming a family but feared loss of independence. Fathers also referred to the impact of parental	QR=18 ( $\kappa=1.0$ )

Table 4. Characteristics of Reviewed Studies continued.

Authors, Date, Country of Origin	Study Aims	Research Design and Sampling Strategy	Sample Size and Participant Characteristics	Method of Data Collection	Data Analysis	Summary of Key Findings	Quality Rating (QR) (Reliability co-efficient)
	pregnancy and the postpartum period.	Maternity Hospitals.	6 men previously divorced. Not stated if fathers had children in previous relationships.  Fathers aged 20-37 years ( $M=31$ years).	information about anticipated emotions, needs and anxieties in the weeks after the birth, anticipated needs and preferred sources of emotional support and information.		roles within society on their identity as a father; <i>2. Preferred sources of information and support</i> – Men recognised social change and that it was more acceptable for men to talk about mental health. <i>3. Role of primary care in mental health for new parents</i> – Fathers reported that their relationship with healthcare professionals was essential for accessing and seeking support.	

## Findings

The systematic synthesis of studies generated two overarching themes: Self-Identity and Help-Seeking. It emerged that fathers' self-identity is challenged at three levels: Identity Confusion, Identity Conflict, and Identity Strain which impacts negatively on mental health (MH). The theme of help-seeking highlighted how fathers experienced barriers to help-seeking. When fathers were able to access formal support this was often experienced negatively, therefore, fathers found informal, pre-existing support networks to be a more positive form of help-seeking. Table 5 displays how each study contributed to each theme and sub-theme.

Table 5. Main Themes and Subthemes

Main Themes	Subthemes
Self-Identity	Identity Confusion: "Once the baby is born you come third" Identity Conflict: "There's still a lot of old school thought" Identity Strain: Work vs. Home
Help-Seeking	Barrier to Help: "It's all done over a beer and a few jokes" Negative Formal Support: "I wouldn't have a clue" Positive Informal Support: "We're supposed to be able to get on with it"

As displayed in Table 6, 11 studies contributed to the main theme of Self-Identity and 13 studies contributed to the main theme of Help-Seeking.

Table 6. Contributions of Studies to Main Themes and Subthemes

Main themes	Self-Identity				Help-Seeking	
Subthemes	Identity Confusion: “Once the baby is born you come third”	Identity Conflict: “There’s still a lot of old school thought”	Identity Strain: Work vs. Home	Barriers to help: “It’s all done over a beer and a few jokes”	Negative Formal Support: “I wouldn’t have a clue”	Positive Informal Support: “We’re supposed to be able to get on with it”
Boddy et al. (2016)	✓				✓	
Dallos and Nokes (2011)	✓	✓	✓			✓
Darwin et al. (2017)	✓	✓	✓	✓	✓	✓
Doucet et al. (2012)				✓	✓	✓
Edhborg et al. (2016)	✓	✓	✓		✓	✓
Engqvist and Nilsson (2011)	✓			✓		
Gervais et al. (2016)	✓				✓	
Johansson et al. (2015)	✓					
Johansson et al. (2016)	✓					
Letourneau et al. (2011)				✓		
Letourneau et al. (2012)				✓	✓	
Marr et al. (2014)					✓	
Reid et al. (2016)			✓	✓		
Rominov et al. (2017)	✓	✓	✓		✓	✓
Rowe et al. (2013)	✓	✓		✓		✓

## ***Self-Identity***

An overarching theme of Self-Identity emerged, which was present in 11 reviewed studies (Table 6). This theme related to how fathers are vulnerable to MH difficulties during the perinatal period as a result of challenges to their self-identity. The three main ways in which fathers' self-identity was undermined were through identity confusion, identity conflict and identity strain. Firstly, the subtheme 'Identity Confusion: "*Once the baby is born, you come third*"' encapsulates how fathers found it difficult to define their role within the family and to navigate the changing relationship with their partner. A second subtheme of 'Identity Conflict: "*There is still a lot of old school thought*"' highlighted how men's expectations were frequently at odds with societal expectations, which impacted on their adjustment to the fathering role. Finally, these changes in self-identity and competing expectations are represented an 'Identity Strain' between the demands of work and home life.

Identity Confusion: "*Once the baby is born you come third*"

Seven studies found that fathers experienced confusion within their role in the family which impacted on their MH (Dallos & Nokes, 2011; Darwin et al., 2017; Edhborg et al., 2016; Gervais et al., 2016; Johansson et al., 2016; Rominov et al., 2017; Rowe et al, 2013). Studies reported that, despite being equal in other areas, fathers felt frustrated at not being considered to have an equal role in parenting and were viewed as having less value than mothers:

*"We have shared (household tasks) even if I have done most of them...then I think...that I also feel that it is still the woman who is the head parent somehow."*

(Edhborg et al., 2016, p.434)

Rowe et al. (2013) found that fathers described themselves as a source of support for the mother rather than an equal co-parent:

*“The mum is steering the ship, that is, you’ve got to be her assistant and help.”*

(Rowe et al, 2013, p.1454)

Some fathers felt that more focus should be on mother and baby rather than themselves. Darwin et al. (2017) and Gervais et al. (2016) reported that fathers placed themselves as being of less importance than mother and baby as they were concerned that highlighting their own emotional needs would take resources away from the mother:

*“I very much feel like it’s certainly not about me, this...They can’t be responsible for everyone, the pregnant woman is the priority.”*

(Darwin et al., 2017, p.22)

Despite redefining their role as a ‘helper’ (Rowe et al., 2013, p.1454), fathers continued to struggle to know how to adequately fulfil this new position:

*“For sure we have a background role. The mother is primordial and that’s normal. But we still have a supporting role, and sometimes I think we do not do a very good job of it.”*

(Gervais et al., 2016, p.131)

In contrast to a defined role as a support for mothers, two studies (Dallos & Nokes, 2011; Gervais et al., 2016) highlighted that fathers were “struggling” (Dallos &

Nokes, 2011, p.157) to find their role and relied on family members for role definition:

*“My mother has given me the impression that my job will be later on, when he’s older, playing with him, entertaining him.”*

(Dallos & Nokes, 2011, p.157)

The majority of studies reported changes in the fathers’ relationships with their partner and a change in role within the family. Nine studies reported that the relationship changes had a negative impact on fathers, with poorer communication, more conflicts with their partner (Dallos & Nokes, 2011; Edhborg et al., 2016) and a loss of closeness within the relationship (Darwin et al., 2017):

*“The relationship is the hardest...when the relationship becomes difficult and strenuous you have nothing to fall back on.”* (Edhborg et al., 2016, p.433)

Navigating the changes from dyad to triad was highlighted as a difficulty for many fathers. Fathers felt surprised and unprepared for the relationship changes. They reported feeling *“pushed out”* (Dallos & Nokes, 2011, p. 154) and experienced further confusion about their role within the family:

*“It’s not about you anymore...once the baby is born you come third don’t you?”*

(Rowe et al, 2013, p.1455)

In contrast, two studies found positive changes in relationships with partners. The studies highlighted an increased sense of responsibility for protecting the family and increased love towards mother and baby (Johansson et al., 2015; Reid et al., 2017):



*“Maybe I love my girlfriend even more now.”*

(Johansson et al., 2015, p. 16)

Identity Conflict: *“There’s still a lot of old school thought”*

The second subtheme to emerge encompassed conflicting expectations of fatherhood. Incongruence between fathers’ own expectations and those of society frequently resulted in shame and psychological distress. Five studies reported that prior expectations of fatherhood impacted on their views of themselves during the perinatal period. One father found himself questioning what it meant to be a *“hands-on, contemporary father”* (Dallos & Nokes, 2011, p.155) whilst other studies reported that fathers perceived a sense of disapproval from society if they took the role as primary caregiver (Rowe et al., 2013). These findings highlighted a contrast between how fathers viewed themselves in comparison to the expectations of others, which undermined their self-identity:

*“There is still a lot of old school thought...yeah, the community and society is probably 80% focused on mother and baby so there is probably a need for change in that area.”*

(Rowe, et al., 2013, p.1454)

Three studies found that fathers did not feel adequately prepared for fatherhood (Darwin et al., 2017; Edhborg et al., 2016; Rominov et al., 2017). They relied on cultural expectations of fatherhood, which resulted in feelings of shame and distress when these conflicted with their own experiences.

*“I guess more awareness, preparation or letting the dad know that potentially, you are not going to have that bond the same as the mother does initially.”*

(Rominov et al., 2017, p.6)

#### Identity Strain: Work vs. Home

The third subtheme to emerge was that of fathers experiencing a strain between work and home life. Fathers reported how the strain between their identities as both a ‘worker’ and a father impacted negatively on their MH. Four studies identified that fathers struggled to balance the competing demands of returning to work and caring for their baby at home (Darwin et al., 2017; Edhborg et al., 2016; Reid et al., 2017; Rominov et al., 2017). Some fathers reported conflict between missing their family when at work but also missing work when at home with their family (Edhborg et al., 2016). Returning to work caused fathers to experience increased stress and guilt due to not being able to support their partner:

*“Not being able to see as much of [baby] as I would like to [is] stressful as well as trying to – worrying about looking after both of them.”*

(Darwin et al., 2017, p.21)

Rominov et al. (2017) found that fathers reported work to be a barrier to engaging with their role as a father, due to the societal expectation that mothers should be the primary caregiver:

*“Even in relatively flexible, family friendly work place, it’s still a kind of male negativity toward fathers taking the day to care for sick kids.”*

(Rominov et al., 2017, p.7)

These findings indicated that inflexible working arrangements and attitudes towards fathers in the workplace, at times, prevented them from engaging with the fathering role in the way that they wished. This internal struggle and strain subsequently impacted negatively on their MH.

### ***Help-Seeking***

The second major theme to emerge from the translated studies was ‘Help-Seeking’ which was reported within 13 studies (see Table 6). This theme highlighted how seeking help for MH difficulties was challenging for fathers for two primary reasons; the stigma related to help-seeking, and the lack of access to reliable, father-specific information. These barriers resulted in fathers relying on personal coping mechanisms and informal support networks. These findings were synthesised into three subthemes; ‘Barriers to Help: *“We’re supposed to be able to get on with it”*’, ‘Negative Formal Help: *“I wouldn’t have a clue”*’ and ‘Positive Informal Help: *“It’s all done over a beer and a few jokes”*’.

#### **Barriers to Help: *“We’re supposed to be able to get on with it”***

This subtheme described how fathers experiencing MH difficulties often delay or avoid accessing support due to help-seeking stigma related to masculine stereotypes of not needing help, in addition to feelings of guilt and shame for taking resources away from mother and baby.

Five studies found that fathers have mixed attitudes towards help-seeking for their own MH. Within four studies (Dallos & Nokes, 2011; Darwin et al., 2017; Doucet et al., 2012; Rominov et al., 2017), fathers minimised their own distress due to feelings of guilt as “[partners] got it a lot worse” (Darwin et al., 2017, p.21), needing to be “strong” for their partner (Doucet et al., 2012, p. 241) and a traditional view of masculinity that stigmatised male help-seeking:

*“As a man I think...it’s always been a perception that we’re supposed to be able to handle it...we’re supposed to be able to get on with it.”*

(Dallos & Nokes, 2011, p.158)

The stigma associated with help-seeking was highlighted in four studies and presented a barrier to fathers seeking support (Doucet et al., 2012; Edhborg et al., 2016; Letourneau et al., 2012; Rowe et al., 2013). Doucet et al. (2012) found that attitudes are changing, suggesting that it is becoming “more acceptable for blokes to talk” (p.1455) about MH difficulties. In contrast, Letourneau et al. (2012) reported that fathers felt that stereotypical gender roles and views of masculinity presented significant barriers to fathers seeking support for their MH. Fathers reported that they did not want to burden others and preferred to keep their difficulties to themselves due to concerns about their pride and privacy (Doucet et al., 2012; Edhborg et al., 2016; Letourneau et al., 2011).

*“It’s more accepting for women to share with her female friends about this stuff and men it’s not, I don’t think, I mean it’s changing but I think a lot of men are stuck in the idea that ...you’re in your own solitude to figure it out.”*

(Letourneau et al., 2011, p.45)

Negative Formal Support: *“I wouldn’t have a clue”*

Negative experiences of accessing formal support emerged as the second subtheme from the synthesised findings. It was highlighted that even when fathers overcame the barriers of help-seeking stigma, they were unaware of where to access reliable, father-specific support. Five studies described how fathers had negative experiences of accessing information and formal support for their own MH:

*“I looked into more of those signs and symptoms [...] It wasn’t what I could do to help myself...what you can do to support yourself or what are some of the support networks that a father might want to turn to.”*

(Letourneau et al., 2012, p.74)

Darwin et al. (2017) reported that fathers were unclear about whether they could access perinatal services for support and instead opted to visit their GP. Other studies also found that fathers felt confused about where to access reputable information (Edhborg et al., 2016; Rominov et al., 2017), whereas other studies found that fathers were reluctant to seek support for themselves due to perceived stigma (Letourneau et al., 2012). Fathers, therefore, relied heavily on mothers for information:

*“My wife spoon-fed me a fair bit, a lot of stuff. I cannot say I would’ve actually been proactive enough to do it myself.”*

(Rominov et al., 2017, p.5)

Three studies reported that fathers desired resources that were specific and targeted towards fathers (Darwin et al., 2017; Letourneau et al., 2012; Rominov et al., 2017).

*“I wouldn’t have a clue how to go about [accessing information] ...with [partner], she can go online and find 28 different chat rooms...I don’t know if those things even exist [for fathers] and I wouldn’t know where to look.”*

(Darwin et al., 2017, p.27)

Four studies included themes relating to experiences of formal support (Darwin et al., 2017; Doucet et al., 2012; Letourneau et al., 2012; Rowe et al., 2013). Fathers experienced formal support in different ways. Some fathers reported that they preferred face-to-face contact with a professional (Doucet et al., 2012) in comparison to group support. Doucet et al. (2012) reported that some fathers found formal individual support beneficial, despite expressing initial reservations:

*“He never judged I mean, sometimes you know, two guys get talking and you’re sitting there like Christ why am I telling this guy this stuff, but he was the type that you could feel comfortable doing that.”*

(Letourneau et al., 2012, p.75)

Other fathers, however, had negative experiences of male-specific support (Darwin et al., 2017; Rowe et al. 2013), such as father-baby groups (Darwin et al., 2017).

Positive Informal Help: *“It’s all done over a beer and a few jokes”*

The final subtheme reflects how, in the absence of formal support, fathers’ experiencing MH difficulties relied more heavily upon informal support. Four studies reported the personal coping mechanisms that fathers used in order to manage the demands of parenthood (Darwin et al., 2017; Engqvist & Nilsson, 2011;

Letourneau et al., 2011; Reid et al., 2017). Fathers used a range of mechanisms to manage their stress, which were predominantly self-reliant and externally focused.

For example, some fathers reported using work as a distraction:

*“I like my work because its technical stuff, I know I can bury myself in that and that will take my mind off it.”* (Darwin et al., 2017, p.25)

Other fathers found *“getting out and going for a run”* (Letourneau et al., 2011, p.44) was a way of coping and managing their stress. Some studies reported that fathers preferred to take a practical, problem-solving approach such as attempting to persuade mothers to take medication recommended by professionals for their psychiatric diagnosis (Darwin et al., 2017, Engqvist & Nilsson, 2011). Letourneau et al. (2012) and Reid et al. (2013) identified a number of unhealthy coping strategies that fathers engaged with in order to manage their stress, such as avoiding social situations, increased alcohol intake and eating an unhealthy diet. In contrast, however, Darwin et al. (2017) also found that becoming a parent bolstered the fathers’ ability to manage other stressors in their life:

*“Having him has given me a focus because when I’ve had the energy doing things with him has just taken my mind completely off everything.”*

(Darwin et al., 2017, p.25)

The majority of fathers were found to seek support informally through pre-existing relationships with friends and family (e.g. Darwin et al., 2017; Rominov et al., 2017). Fathers found this to be valuable as they were able to intersperse their concerns with light-hearted conversation:

*“You know we do talk to each other about parenting stuff but...it’s never a serious conversation, it’s all, done over a beer you know and a few jokes, which is good.”*

(Darwin et al., 2017, p.27)

This offered fathers a “*listening ear*” (Doucet, et al., 2012, p.241) from an individual with whom they already felt comfortable with. However, in studies where fathers’ partners were experiencing mental health difficulties, the limitations of these informal support networks were highlighted. Fathers reported that friends and family did not adequately understand their partners’ diagnosis and, therefore, meeting others in similar situations was the most beneficial source of support.

*“Just to meet people who were saying, yep I was bad. And your situation was nothing like mine and mine is nothing like yours, but I made it.”*

(Letourneau et al., 2011, p.44)

## **Discussion**

### ***Summary of Findings***

The primary aim of this meta-ethnography was to broaden findings from previous reviews and systematically review the qualitative research exploring both first-time and subsequent fathers’ experiences of perinatal mental health (PMH) difficulties. Through systematic synthesis of the 15 studies identified, fathers’ experiences of PMH difficulties were encapsulated within two overarching themes, Self-Identity and Help-Seeking, which incorporated six subthemes. The first main theme highlighted that fathers are vulnerable to MH difficulties because the perinatal period



poses challenges to self-identity. The synthesised literature suggested that fathers' identity was impacted at three levels; Identity Confusion, Identity Conflict and Identity Strain. Fathers face worsening MH if unable to access appropriate support. Despite this, the second main theme highlighted that help-seeking is difficult for fathers due to the presence of stigma and lack of targeted, father-specific information. This resulted in fathers relying on personal support mechanisms and existing, informal networks for support. Subsequently, this review has increased understanding into the mechanisms that make fathers vulnerable to mental health difficulties during the perinatal period and highlighted the importance of supporting fathers in the transition from 'partner' to 'parent'. This meta-ethnographic review has provided new insights into fathers' preferred support mechanisms and highlights how fathers found informal support networks to be particularly beneficial, even when formal support was offered this was often perceived as less helpful.

The first theme emphasised how fathers' experiences are defined by confusion, conflict, and strain relating to self-identity, which causes stress, anxiety and frustration for fathers, impacting negatively on their MH. This supports existing research which highlighted that fatherhood is characterised by changing role and identity within the family (Chin et al., 2011; Kowlessar et al., 2014). Fathers developed a new identity as a support for their partner, rather than having an equal role in parenting, and experienced their new role as devalued and of less importance than the mothering role. During challenges to identity, minimisation of this new role can act as a coping mechanism (Thoits, 2012), however, may result in fathers being

reluctant to seek support for their own MH due to feeling unentitled and less deserving than mothers.

Consistent with previous reviews, these findings suggest that fathers may struggle as their self-identity is undermined (Baldwin et al., 2018), causing distress and feelings of detachment as their role is devalued (Chin et al, 2011). This is evident within the identity strain that fathers experience, particularly as the role of a father within society is changing. There exists a tension between the ‘breadwinner ideology’ of fathers’ roles being within the domain of accessing paid work (Lewis, 2001) and the new ideology of “*caring masculinity*” (Hunter et al., 2017, p.3) whereby fathers are expected to be increasingly emotionally available for their children. The distinct gender roles present within the perinatal period (Doucet, 2009a) contribute to the identity confusion and conflict experienced by fathers as they are expected to navigate opposing expectations.

The present findings are consistent with current issues regarding gender roles, masculinity and fatherhood and are particularly evident in the identity strain between work and home. Being unable to balance these demands was a source of stress for fathers, impacting negatively on their mental health. The current findings go beyond the previous research by providing a more detailed understanding of the nature of self-identity and indicated the central role of self-identity in paternal PMH difficulties.

These findings also suggested that help-seeking stigma and negative experiences of accessing formal support resulted in fathers being less likely to seek help when required. Some, therefore, relied on personal coping and informal support mechanisms. Fathers exhibited a range of personal coping strategies that were predominantly self-reliant, such as exercise, drinking alcohol or unhealthy eating. They also relied on pre-existing support networks to compensate for a lack of awareness of, or access to, formal support. Talking to friends and family in informal settings appeared to make most participants feel more relaxed and enabled conversations to move from serious to less serious topics, which facilitated fathers' emotional expression. These findings are consistent with research suggesting that men talk about mental health and emotional distress differently to women and therefore different support mechanisms and services are needed (Robertson et al., 2015). When formal support networks, such as individual therapy and support groups, were offered and accessed there was a mixed response amongst fathers. Formal support systems were particularly valued when fathers' partners were experiencing significant MH difficulties. It may be that when the focus is moved towards their partners, fathers feel more able to access formal support for themselves, indicating that there continues to be guilt, shame and/or stigma attached to help-seeking in fathers. Although fathers reported positive experiences of informal support, the consequences of not accessing formal support services may contribute towards worsening mental health.

The current review was consistent with previous literature which suggested that fathers felt excluded and devalued by healthcare services. However, these findings

provide a new understanding of how barriers to help-seeking contribute towards worsening PMH for fathers. Although these findings begin to highlight some of the preferred mechanisms for help-seeking and acknowledge the impact of self-identity on paternal PMH, it remains unclear what sources of formal support will be most effective and accessible for fathers.

### ***Clinical Implications***

The findings of this review indicate that fathers experience changing self-identity and often feel marginalised and excluded from healthcare services which is impacting upon their help-seeking behaviour and subsequently their MH. In order for improvements to be made, increasing awareness of paternal PMH issues at both professional and wider public policy level is crucial. Based on the current findings, there are a number of ways that this could be achieved.

Firstly, unequal parenting roles were found to contribute towards identity confusion and conflict, therefore, supporting fathers to feel more involved throughout the perinatal period may have a positive impact on their MH. As previously stated, the MH of fathers impacts upon outcomes for mother and child (Paulson & Bazemore, 2010), therefore, supporting fathers to feel valued and included within healthcare services will have implications for the family system and potentially provide a cost-effective way of improving perinatal mental health services within the NHS. By addressing all midwifery appointments to both parents, providing basic provisions for fathers in maternity wards during labour (e.g. beds for fathers to stay with the

mother) and directly asking fathers about their adjustment and emotional wellbeing may help fathers to feel more involved from the beginning of pregnancy.

The second theme emphasised the need to reduce help-seeking stigma in order to encourage fathers to ask for help when required. At a clinical practice level, professionals in contact with new parents should take the lead on promoting the support systems available for fathers. It is likely that fathers will feel unentitled to support or stigmatised for experiencing psychological distress, therefore, they may not be forthcoming in asking for support directly (Yousaf et al., 2015).

Ways to reduce help-seeking stigma for fathers experiencing PMH difficulties should also be considered at a wider policy level. The recent long-term plan outlined by NHS England (Stevens, 2018) highlighted that more funding for PMH services will be available and includes specific recommendations that fathers whose partners are experiencing MH difficulties should be offered MH screening. The findings of this review suggest that MH screening of all fathers should be considered. Current assessment tools have not been validated for use with fathers and are currently designed with maternal MH in mind (Massoudi et al., 2013), therefore, further research is required in order to develop measures specifically designed to assess paternal PMH difficulties. Routinely asking about father's MH at stages throughout the perinatal period, providing education, and offering individual sessions may assist in the reduction of help-seeking stigma (Griffiths et al., 2014).

The current findings highlighted the need to improve fathers' experiences of accessing formal support during the perinatal period. Fathers were unaware of where to access reliable information relating to their own mental health needs. Father-centric, as opposed to 'mother-centric' (Ball, 2009) resources and information need to be available. The format of this information could be presented in the form of an information pack during antenatal classes, or the development of an 'App' for fathers (or birth partners) which signposts to information and support. Such apps are widely available for mothers but do not directly address the role of fathers. Information relating to 'how you and your partner can support each other' at each stage throughout the perinatal period may serve to increase access to targeted support as well as promote more equal involvement for mothers and fathers at each stage.

Finally, it is clear that fathers prefer to have support in a variety of formats that may differ to the preferences of mothers. The provision of informal support networks for fathers, such as peer mentoring may encourage fathers to attend and allow discussions about stress and MH alongside lighter topics. For example, sports based interventions for men with severe MH difficulties have been shown to be effective in improving wellbeing and emotional connectedness (Friedrich & Mason, 2017). Sports groups for fathers experiencing PMH difficulties may provide invaluable peer support in an informal environment, as well as minimising help-seeking stigma.

### ***Strengths and Limitations***

To the author's knowledge, this is the first review to synthesise the recent literature exploring all fathers' experiences of PMH difficulties. Overall, the findings support the existing research which suggests that fathers can feel devalued and unimportant (Chin et al., 2011; Kowlessar et al., 2014; Taylor et al., 2017). This review, however, offers new insights into how identity, and experiences of help-seeking combine to leave fathers vulnerable to MH difficulties during the perinatal period.

In addition to these strengths, there are also some limitations which require further discussion. There is debate within the literature regarding the validity of reviewing qualitative literature. Some researchers argue that synthesising qualitative research steps away from the interpretivist epistemological position of qualitative research and dilutes the rich, contextual detail explored within the research (Sandelowski et al., 1997). Although there are no set guidelines for reviewing qualitative research (Britten et al., 2002), the current review has followed existing recommendations by Noblit and Hare (1988) to systematically identify and review the existing literature in an attempt to progress our knowledge and understanding in an important field of study. Another common criticism of qualitative review methodology is the level of interpretation brought by the researcher, in which the researcher is adding a third level of interpretation to the study's findings (Sandelowski, 2006). The current review attempted to address this limitation throughout by consulting with a research team to increase reflexivity.

It is argued that the findings of systematic reviews are limited by the quality of primary research included (Britten et al., 2011), therefore, quality assessment is a key feature of robust systematic reviews (Saini & Shlonsky, 2012). The majority of papers included within the current review were assessed to be of sufficiently high quality, however, there were some methodological limitations that should be considered. The three lowest scoring articles (Doucet et al., 2012; Engqvist & Nilsson, 2011; Johansson et al., 2015) were critiqued for the lack of validation checking and reflexivity which diminish the credibility and trustworthiness of findings. Engqvist and Nilsson (2011) and Johansson et al. (2015) were also assessed to lack detail regarding their sampling strategy. Johansson et al. (2015) and Johansson et al. (2016) both employed mixed methodology whereby qualitative data was collected through a survey design, thereby limiting the depth of the data collected. Similarly, Engqvist and Nilsson (2011) collected data from online narratives. Findings from these studies may lack the depth and richness of interview data collected within the other reviewed studies. They were, therefore, taken with caution and triangulated with more robust, high quality studies to ensure that the subsequent conclusions and clinical implications were robust.

Furthermore, in order to identify relevant studies, the inclusion criteria stated that fathers or their partners must have accessed MH services. Given that men frequently avoid seeking support for their mental health (Yousaf et al., 2015) and there is a general lack of recognition and awareness relating to paternal perinatal mental health difficulties, the findings of this meta-ethnographic review are limited to those fathers who have been able to overcome the barriers to help-seeking. These findings do,



however, increase understanding of paternal perinatal mental health experiences and go some way to suggesting how services can increase accessibility of services to fathers who feel stigmatised and marginalised.

### ***Directions for Future Research***

The current findings have highlighted a number of important directions for future research. As the studies reviewed were all conducted within Western societies, the conclusions drawn, relating to fatherhood identity and help-seeking stigma, may be specific to Western value bases. Research suggests that the role of parenting and fatherhood involvement varies across cultures (Toth & Xu, 1999), however, no existing research within different cultures was identified within the systematic search. Fathers' experiences of PMH difficulties and experiences of seeking support across different cultures is, therefore, an important area for future research to highlight similarities and differences between fathers' experiences.

This review acknowledged that traditional gender roles appear to play a role in fathers' experiences of seeking help. As societal views about gender evolve, it is unclear how this will impact upon male caregivers' role and identity. Studies of fathers in same-sex relationships have shown that the absence of stereotyped gender roles within the relationship resulted in more equal caregiving (Biblarz & Stacey, 2010). It is unclear whether these more equal roles would increase a father's feeling of marginalisation from healthcare services or whether this different role would provide a different experience within the perinatal period. Linked to the finding that

fathers in heterosexual relationships view themselves as a support for their female partner, it would be interesting to explore how the fathering role differs for those in same-sex relationships, where neither parent has given birth. Furthermore, no research was identified exploring the experiences of non-biological fathers during this period. There is clearly a paucity of literature exploring the experiences of non-biological fathers, such as adoptive and step-fathers, which future research may wish to address in order to support and understand a wide range of fatherhood experiences.

This review focuses solely on fathers' PMH experiences. Within existing literature, there is limited research combining mothers' and fathers' experiences. However, there is a strong evidence base to suggest that paternal and maternal MH difficulties are correlated. This means that qualitative research with couples, to explore the experiences of co-parenting when MH difficulties are present within the relationship, may offer further insights into this area and inform family-based approaches to PMH support.

Finally, current findings emphasise the lack of knowledge and awareness of paternal MH difficulties within perinatal services. For this reason, further qualitative research may wish to triangulate the accounts of parents experiencing MH difficulties with the experiences of healthcare professionals to inform clinical practice. This research direction may highlight potential ways of increasing awareness and enhancing fathers' involvement with services.

## **Conclusion**

Overall, the current meta-ethnographic review has synthesised fathers' experiences of mental health difficulties during the perinatal period in more depth, adding clarity and increased understanding to the existing knowledge base. Although fathers often reported feeling excluded and unentitled to support, findings also highlighted that fathers have a range of personal coping mechanisms including accessing support in more informal ways. This review has important implications for healthcare professionals working with new parents as although fathers, at times, wish to access further support and information, the focus is often on mother and baby. Healthcare professionals should keep fathers in mind and directly offer information that is father-specific in order to reduce stigma and enable fathers to receive additional support relating to their emotional health and wellbeing as required.

## References

- Ashford, M. T., Olander, E. K. & Ayers, S. (2016). Computer- or web-based interventions for perinatal mental health: A systematic review. *Journal of Affective Disorders*, 197, 134-146. doi: 10.1016/j.jad.2016.02.057.
- Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A. & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, 8, 21. doi: 10.1186/1471-2288-8-21.
- Baldwin, S., Malone, M., Sandall, J. & Bick, D. (2018). Mental health and wellbeing during the transition to fatherhood: a systematic review of first time fathers' experiences. *JBIS Database of Systematic Reviews and Implementation Reports*, 16, 2118-2191. doi: 10.11124/JBISRIR-2017-003773.
- Ball, J. (2009). Fathering in the shadows: Indigenous fathers and Canada's colonial legacies. *The Annals of the American Academy of Political and Social Science*, 624, 29-48. doi: 10.1177/0002716209334181.
- Barroso, J., Gollop, C., Sandelowski, M., Meynell, J., Pearce, P. & Collins, L. (2003). The challenge of searching for and retrieving qualitative studies. *Western Journal of Nursing Research* 25(2), 53-178. doi: 10.1177/0193945902250034.
- Bauer, A., Parsonage, M., Knapp, M., Iemmi, V. & Adelaja, B. (2014). *The costs of perinatal mental health problems*. UK: LSE and Centre for Mental Health. Retrieved from: [https://www.nwscnsenate.nhs.uk/files/3914/7030/1256/Costs\\_of\\_perinatal\\_mh.pdf](https://www.nwscnsenate.nhs.uk/files/3914/7030/1256/Costs_of_perinatal_mh.pdf).

- Biblarz, T. J. & Stacey, J. (2010). How does the gender of parents matter? *Journal of Marriage and Family*, 72, 3-22. doi: 10.1111/j.1741-3737.2009.00678.x.
- Boddy, R., Gordon, C., MacCallum, F. & McGuinness, M. (2017). Men's experiences of having a partner who requires Mother and Baby Unit admission for first episode postpartum psychosis. *Journal of Advanced Nursing*, 73(2), 399-409. doi: 10.1111/jan.13110.
- Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M. & Pill, R. (2002). Using meta-ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research and Policy*, 7, 209-215. doi: 10.1258/135581902320432732.
- Britten, N., Campbell, R., Pound, P., Morgan, M., Daker-White, G., Pill, R. & Yardley, L. (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment*, 15(43), 1–164. doi: 10.3310/hta15430.
- Britten, N. & Pope, C. (2011). Medicine taking for asthma: a worked example of meta-ethnography. In K. Hannes & C. Lockwood (Eds). *Synthesizing Qualitative Research: Choosing the Right Approach*. UK: John Wiley and Sons Ltd.
- Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C. & Donovan, J. (2011). Evaluating meta-ethnography: Systematic analysis and synthesis of qualitative research. *Health Technology Assessment*, 15(43), 1–164. doi: 10.3310/hta15430.

- Chin, R., Hall, P. & Daiches, A. (2011). Fathers' experiences of their transition to fatherhood: A meta-synthesis. *Journal of Reproductive and Infant Psychology*, 29, 4–18. doi: 10.1080/02646838.2010.513044.
- Cooklin, A. R., Giallo, R., Strazdins, L., Martin, A., Leach, L. S. & Nicholson, M. (2015). What matters for working fathers? Job characteristics, work-family conflict and enrichment, and fathers' postpartum mental health in an Australian cohort. *Social Science and Medicine*, 146, 214-222. doi: 10.1016/j.socscimed.2015.09.028.
- Cowan, C. P. & Cowan, P. A. (2000). *When partners become parents: The big life change for couples*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Dallos, R. & Nokes, L. (2011). Distress, Loss and Adjustment Following the Birth of a Baby: A Qualitative Exploration of One New Father's Experiences. *Journal of Constructivist Psychology*, 24(2), 144-167. doi: 10.1080/10720537.2011.548223.
- Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L. & Gilbody, S. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth*, 17, 45. doi: 10.1186/s12884-017-1229-4.
- Department of Health. (2011). *'No Health without Mental Health': A cross-government mental health outcomes strategy for people of all ages*. London: HM Government. Retrieved from:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213761/dh\\_124058.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf).

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R. & Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology*, 6, 35. doi: 10.1186/1471-2288-6-35.

Doucet, A. (2009a). Dad and Baby in the First Year: Gendered Embodiment. *The Annals of the American Academy of Political and Social Sciences*, 624, 78-98. doi: 10.1177/0002716209334069.

Doucet, S., Letourneau, N. & Blackmore, E. R. (2012). Support Needs of Mothers Who Experience Postpartum Psychosis and their Partners. *JOGNN*, 41, 236-245. doi: 10.1111/J.1552-6909.2011.01329.x

Doyle, L. H. (2003). Synthesis through meta-ethnography: paradoxes, enhancements, and possibilities. *Qualitative Research*, 3(3), 321–344. doi: 10.1177/1468794103033003.

Edhborg, M., Carlberg, M., Simon, F. & Lindberg, L. (2016). “Waiting for Better Times”: Experiences in the First Postpartum Year by Swedish Fathers with Depressive Symptoms. *American Journal of Men’s Health*, 10(5), 428-439. doi:10.1177/1557988315574740.

Engqvist, I. & Nilsson, K. (2011). Men’s experience of their partners’ postpartum psychiatric disorders: narratives from the internet. *Mental Health in Family Medicine*, 8, 137-146.

- Figueiredo, B. & Conde, A. (2011) Anxiety and depression symptoms in women and men from early pregnancy to 3-months postpartum: Parity differences and effects. *Journal of Affective Disorders*, 132, 146-157. doi: 10.1016/j.jad.2011.02.007.
- Friedrich, B. & Mason, O.J. (2017). “What is the score?” A review of football-based public mental health interventions. *Journal of Public Mental Health*, 16(4), 144-158. doi: 10.1108/JPMH-03-2017-0011.
- Gentile, S. & Fusco, M. L. (2017). Untreated perinatal paternal depression: Effects on offspring. *Psychiatry Research*, 252, 325-332. doi: 10.1016/j.psychres.2017.02.064.
- Gervais, C., de Montigny, F., Lacharité, C. & St-Arneault, K. (2016). Where Fathers Fit in Quebec’s Perinatal Health Care Services System and What They Need. *Psychology of Men and Masculinity*, 17, 126-136. doi: 10.1037/a0039558.
- Goodman, J. H. (2004b). Paternal postpartum depression, its relationship to maternal postpartum depression and implications for family health. *Journal of Advanced Nursing*, 45, 26-35. doi: 10.1046/j.1365-2648.2003.02857.x.
- Griffiths, K. M, Carron-Arthur, B., Parsons, A. & Reid, R. (2014). Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized, controlled trials. *World Psychiatry*, 13(2), 161–175. doi: 10.1002/wps.20129.
- Halbreich, U. & Karkun, S. (2006). Cross-cultural and social diversity of prevalence of postpartum depression and depressive symptoms. *Journal of Affective Disorders*, 91, 97-111. doi: 10.1016/j.jad.2005.12.051.



- Hannes, K. & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: Update on a review of published papers. *Qualitative Research*, 12(4), 402–442. doi: 10.1177/1468794111432992.
- Hunter, S. C., Riggs, D. W. & Augoustinos, M. (2017). Hegemonic masculinity versus a caring masculinity: Implications for understanding primary caregiving fathers. *Social and Personality Psychology Compass*, 11, e12307. doi: 10.1111/spc3.12307.
- Johansson, M., Edwardsson, C. & Hildingsson, I. (2015). The ‘Pregnant Man’ – Expecting Fathers Experience Pregnancy-related Changes: A longitudinal study with a mixed method approach. *Journal of Men’s Health*, 11, 8-18. Retrieved from: <https://jomh.org/index.php/JMH/article/view/16/7>.
- Johansson, M., Thomas, J., Hildingsson, I. & Haines, H. (2016). Swedish fathers contemplate the difficulties they face in parenthood. *Sexual and Reproductive Healthcare*, 8, 55-62. doi: 10.1016/j.srhc.2016.02.005.
- Kamalifard, M., Hasanpoor, S., Babapour, J., Kheiroddin, S., Panahi, E., Payan, S. & Bayati, A. (2014). Relationship between fathers' depression and perceived social support and stress in postpartum period. *Journal of Caring Sciences*, 3, 57-66. doi: 10.5681/jcs.2014.007.
- Kim, P. & Swain, J. E. (2007). Sad Dads: Paternal Postpartum Depression. *Psychiatry (Edgmont)*, 4, 35-47. Retrieved from: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922346/pdf/PE\\_4\\_2\\_36.pdf](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922346/pdf/PE_4_2_36.pdf).

- Kmet, L. M., Lee, R. C. & Cook, L. S. (2004). *Standard quality assessment criteria for evaluating primary research papers from a variety of fields*. Edmonton: Alberta Heritage Foundation for Medical Research (AHFMR). doi: 10.7939/R37M04F16.
- Kowlessar, O., Fox, J.R. & Wittowski, A. (2015) The pregnant male: a meta-synthesis of first-time fathers' experiences of pregnancy. *Journal of Reproductive and Infant Psychology*, 33, 106-127. doi: 10.1080/02646838.2014.970153.
- Kuper, A., Lingard, L. & Levinson, W. (2008). Critically appraising qualitative research. *British Medical Journal*, 337, 687-692. doi: 10.7939/R37M04F16.
- Leach, L. S., Poyser, C., Cooklin, A. R. & Giallo, R. (2016). Prevalence and course of anxiety disorders (and symptom levels) in men across the perinatal period: A systematic review. *Journal of Affective Disorders*, 190, 675-689. doi: 10.1016/j.jad.2015.09.063.
- Letourneau, N., Duffett-Leger, L., Dennis, C.L., Stewart, M. & Tryphonopoulos, P.D. (2011). Identifying the support needs of fathers affected by post-partum depression: a pilot study. *Journal of Psychiatric and Mental Health Nursing*, 18, 41-47. doi: 10.1111/j.1365-2850.2010.01627.x.
- Letourneau, N., Panagioti, D., Tryphonopoulos, P., Duffett-Leger, L., Stewart, M., Benzies, K., Dennis, C.L. & Joschko, J. (2012). Support Intervention Needs and Preferences of Fathers Affected by Postpartum Depression. *Journal of Perinatal and Neonatal Nursing*, 26, 69-80. doi: 10.1097/JPN.0b013e318241da87.

- Lewis, J. (2001). The Decline of the Male Breadwinner Model: The Implications for Work and Care. *Social Politics*, 8(2), 152-170. doi: 10.1093/sp/8.2.152.
- Marrs, J., Cossar, J. & Wroblewska, A. (2014). Keeping the family together and bonding: a father's role in a perinatal mental health unit. *Journal of Reproductive and Infant Psychology*, 32(4), 340-364. doi: 10.1080/02646838.2014.920951.
- Massoudi, P., Hwang., C. P. & Wickberg, B. (2013). How well does the Edinburgh Postnatal Depression Scale identify depression and anxiety in fathers? A validation study in a populated based Swedish sample. *Journal of Affective Disorders*, 149, 67-74. doi: 10.1093/sp/8.2.152.
- McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochemia medica*, 22(3), 276-282. doi: 10.11613/BM.2012.031.
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D.G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*, 151(4), 264–269. doi:10.7326/0003-4819-151-4-200908180-00135.
- National Institute for Health and Care Excellence (NICE). (2014). *Antenatal and postnatal mental health: clinical management and service guidance*. Clinical Guideline 192. London: National Institute for Health and Care Excellence. Retrieved from: <https://www.nice.org.uk/guidance/cg192/evidence/full-guideline-pdf-4840896925>.
- Nilni, Y. I., Mehralizade, A., Mayer, L. & Milanovic, S. (2018). Treatment of depression, anxiety, and trauma-related disorders during the perinatal period:

- A systematic review. *Clinical Psychology Review*, 66, 136-148. doi: 10.1016/j.cpr.2018.06.004.
- Noblit, G. W. & Hare, R. D. (1988). *Meta-ethnography: Synthesising qualitative studies*. Newbury Park, CA: Sage.
- Nyström, K. & Öhrling, K. (2004). Parenthood experiences during the child's first year: literature review. *Journal of Advanced Nursing*. 46(3), 319-330. doi:10.1111/j.1365-2648.2004.02991.x.
- Office for National Statistics (2016). *Suicides in Great Britain, 2016 Registrations - ONS*. London: Office for National Statistics. Retrieved September 2018 from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages>.
- Oldfield, V. & Carr, J. (2017). Postnatal depression: Student health visitors' perceptions of their role in supporting fathers. *Journal of Health Visiting*, 5, 143-149. doi: 10.11613/BM.2012.031.
- Paterson, B. L. (2012). "It looks great but how do I know if it fits?": An introduction to meta-synthesis research. In K. Hannes & C. Lockwood (Eds). *Synthesizing Qualitative Research: Choosing the Right Approach*. UK: John Wiley and Sons Ltd.
- Paulson, J. F., Dauber, S. & Leiferman, J. A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behaviour. *Paediatrics*, 118(2), 659–668. doi: 10.1542/peds.2005-2948.
- Paulson, J. F. & Bazemore, M. S. (2010). Prenatal and Postpartum Depression in Fathers and Its Association with Maternal Depression: A Meta-analysis. *The*

- Journal of the American Medical Association*, 303(19), 1961–1969.  
doi:10.1001/jama.2010.60.
- Philpott, L. F. & Corcoran, P. (2018). Paternal postnatal depression in Ireland: Prevalence and associated factors. *Midwifery*, 56, 121-127. doi: 10.11613/BM.2012.031.
- Poh, H. L., Koh, S. S. L. & He, H. G. (2014). An integrative review of fathers' experiences during pregnancy and childbirth. *International Nursing Review*, 61, 543-554. doi: 10.1111/inr.12137.
- Pope, C., Mays, N. & Popay, J. (2007). *Synthesizing qualitative and quantitative health evidence: a guide to methods*. Buckingham: Open University Press.
- Quevedo, L., da Silva, R. A., Coelho, F., Pinheiro, K. A., Horta, B. K., Kapczinski, F. & Pinheiro, R. T. (2011). Risk of suicide and mixed episode in men in the postpartum period. *Journal of Affective Disorders*, 132, 243-246. doi: 10.1016/j.jad.2011.01.004.
- Ramchandani, P., Stein, A., Evans, J. & O'Connor, T.G. (2005). Paternal depression in the postnatal period and child development: a prospective population study. *Lancet*, 365(9478), 2201-2205. doi: 10.1016/S0140-6736(05)66778-5.
- Ramchandani, P.G., O'Connor, T.G., Evans, J., Heron, J., Murray, L. & Stein, A. (2008). The effects of pre- and postnatal depression in fathers: a natural experiment comparing the effects of exposure on offspring. *Journal of Child Psychology and Psychiatry*, 49, 1069-1078. doi: 10.1111/j.1469-7610.2008.02000.x.

Reid, H., Wieck, A., Matrunola, A. & Wittkowski, A. (2016). The Experiences of Fathers When Their Partners are Admitted with Their Infants to a Psychiatric Mother and Baby Unit. *Clinical Psychology and Psychotherapy*, 24(4), 919-931. doi: 10.1002/cpp.205.

Robertson, S., White, A., Gough, B., Robinson, M., Seims, A., Raine, G. & Hanna, E. (2015). Promoting Mental Health and Wellbeing with Men and Boys: What Works? *Movember Foundation and Centre for Men's Health at Leeds Beckett University*. Retrieved March 2019 from <https://www.menshealthforum.org.uk/best-practice-mental-health-promotion>.

Rominov, H., Pilkington, P.D., Giallo, R. & Whelan, T.A. (2016). A Systematic Review of Interventions Targeting Paternal Mental Health in the Perinatal Period. *Infant Mental Health Journal*, 37 (3), 289-301. doi: 10.1002/imhj.21560

Rominov, H., Giallo, R., Pilkington, P. D. & Whelan, T. A. (2017). "Getting Help for Yourself is a Way of Helping Your Baby:" Fathers' Experiences of Support for Mental Health and Parenting in the Perinatal Period. *Psychology of Men and Masculinity*, 19(3), 457-468. doi: 10.1037/men0000103.

Rowe, H. J., Holton, S. & Fisher, J. R. (2013). Postpartum Emotional Support: A Qualitative Study of Women's and Men's Anticipated Needs and Preferred Sources. *Australian Journal of Primary Health*, 19(1), 1448-1527. doi: 10.1071/PY11117.

Saini, M. & Shlonsky, A. (2012). *Systematic Synthesis of Qualitative Research*. Oxford: Oxford University Press.

- Sandelowski, M., Docherty, S. & Emden, C. (1997). Qualitative meta-synthesis: issues and techniques. *Research in Nursing and Health*, 20, 365-371. doi: 10.1177/1053815111425493.
- Sandelowski, M. (2006). "Meta-Jeopardy": The crisis of representation in qualitative metasynthesis. *Nursing Outlook*, 54, 10-16. doi: 10.1016/j.outlook.2005.05.004.
- Shaw, R.L. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, 7(3), 233-243. doi: 10.1080/14780880802699092.
- Simms, C. & Scowcroft, E. (2018). *Suicide Statistics Report: Latest Statistics for UK and Republic of Ireland*. UK: Samaritans.
- Steen, M., Downe, S., Bamford, N. & Edozien, L. (2011). Not-patient and not-visitor: A meta-synthesis of fathers' encounters with pregnancy, birth and maternity care. *Midwifery*, 28, 362–371. doi: 10.1016/j.midw.2011.06.009.
- Stevens, S. (2018). *Partners of new mums with mental illness set to get targeted support on the NHS*. London: NHS England. Retrieved April 2019, from <https://www.england.nhs.uk/2018/12/partners-of-new-mums-with-mental-illness-set-to-get-targeted-support-on-the-nhs>.
- Sweeney, S. & MacBeth, A. (2016). The effects of paternal depression on child and adolescent outcomes: A systematic review. *Journal of Affective Disorders*, 205, 44-59. doi: 10.1016/j.jad.2016.05.073.

- Taylor, B.L., Billings, J., Morant, N. & Johnson, S. (2017). How do women's partners view perinatal mental health services? A qualitative meta-synthesis. *Clinical Psychology and Psychotherapy*, 25, 112-129. doi: 10.1002/cpp.2133.
- Thoits, P.A. (2012). Self, Identity, Stress and Mental Health. In C. S. Aneshensel, J. C. Phelan & A. Bierman (Eds). *Handbook of the Sociology of Mental Health*. New York: Springer.
- Thomas, J. & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8(45). doi: 10.1186/1471-2288-8-45.
- Toth, J. F. & Xu, X. (1999). Ethnic and Cultural Diversity in Fathers' Involvement: A Racial/Ethnic Comparison of African American, Hispanic, and White Fathers. *Youth and Society*, 31, 76-99. doi: 10.1177/0044118X99031001004.
- Twamley, K. & Schober, P. (2019). Shared Parental Leave: Exploring Variation in Attitudes, Eligibility, Knowledge and Take-up Intentions of Expectant Mothers in London. *Journal of Social Policy*, 48(2), 387-407. doi: 10.1017/S0047279418000557.
- Walsh, D. & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery*, 22, 108–119. doi: 10.1016/j.midw.2005.05.004.
- Wilson, S. & Durbin, C. (2010). Effects of paternal depression on fathers' parenting behaviours: a meta-analytic review. *Clinical Psychology Review*, 30, 167-180. doi: 10.1016/j.cpr.2009.10.007.
- Wong, O., Nguyen, T., Thomas, N., Thomson-Salo, F., Handrinos, D. & Judd, F. (2016). Perinatal mental health: Fathers – the (mostly) forgotten parent. *Asia-*



*Pacific psychiatry: official journal of the Pacific Rim College of Psychiatrists*, 8(4), 247-255. doi: 10.1111/appy.12204.

World Health Organisation. (2005). *Promoting Mental Health: Concepts, Emerging Evidence, and Practice*. World Health Organisation: Geneva. Retrieved from: [https://www.who.int/mental\\_health/evidence/en/promoting\\_mhh.pdf](https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf).

Wynne-Edwards, K. E. (2001). Hormonal Changes in Mammalian Fathers. *Hormones and Behaviour*, 40, 139-145. doi: 10.1006/hbeh.2001.1699.

Yousaf, O., Grunfeld, E. A. & Hunter, M. S. (2015). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review*, 9(2), 264-276. doi: 10.1080/17437199.2013.840954.

## **Chapter II: Empirical Research**

**‘Mad, Sad and Bad’ to ‘Dad’: Care-experienced Men’s Experiences of  
Fatherhood**

Chapter Word Count at Time of Submission: 7, 999  
(excluding abstract, tables, figures and references)

Formatted for publication within the *British Journal of Psychology* (see Appendix G  
for author submission guidelines)

## Abstract

**Aim:** The transition to fatherhood can have a significant impact upon fathers' emotional health and wellbeing. Experiences of physical, sexual and emotional abuse in childhood correlates with increased rates of depression, self-harm and suicide in adulthood. For fathers who have care experience, therefore, the transition to parenthood may have a greater impact on mental health. Previous research has highlighted the importance of the father-child relationship in child development. Despite this, little research has focused on fatherhood from the perspective of males with care experience. This study aimed to explore the lived experiences of fathers with care experience. **Method:** Five participants completed semi-structured interviews and data was analysed using Interpretative Phenomenological Analysis (IPA). **Findings:** Three key superordinate themes emerged; '*Going Back to Move Forward*', '*Reliving the Past*' and '*Breaking the Cycle*' that encapsulated eight subordinate themes. **Conclusions:** Participants described being a father as a chance to relive their childhood and feel accepted as part of a family which impacted positively on their sense of self from "Mad, Sad and Bad" to Dad. Clinical implications for policy and practice, as well as directions for future research are explored.

**Keywords:** *Care-experienced, Fathers, Lived Experience, Parenthood, Qualitative*

## **Introduction**

There is a general lack of research on fathers (Lamb & Lewis, 2010), particularly those who have experience of being in Local Authority Care (LAC) at some stage in their childhood (Coleman, 2001). Care-leavers are legally defined as individuals between the ages of 16 and 25 who were in Local Authority Care on their 16<sup>th</sup> birthday and are subsequently eligible for support with housing, finances and education (Department of Health, 2000). The term ‘care experienced’, however, is a broader term used to refer to any adult who was placed under the care of the Local Authority as child for safeguarding reasons, for example in a residential children’s home or foster care (. For the purposes of the current research, fathers are defined as men with at least one biological child.

Whilst the transition to parenthood can be a stressful period for parents (Cowan & Cowan, 2000), little is known about the specific experiences of fathers who have experienced neglectful, abusive and/or inconsistent parenting as a child and are often described as a ‘hard-to-reach’ population (Shaghghi, Bhopal & Sheikh, 2011). It is known that adverse childhood experiences impact on mothers’ adjustment to parenthood causing increased anxiety and difficulties with bonding (Oosterman, Schuengel, Forrer & De Moor, 2019). However, the voices of fathers who have experienced childhood adversity have been overlooked in research. This study aims to explore the lived experiences of fathers who were placed into LAC during childhood. Through in-depth exploration of their experiences, it is hoped that an increased understanding of the support needs of care-experienced fathers will help to inform policy and practice.

## **The Impact of Care Experience on Fatherhood**

The transition to parenthood is potentially an overwhelming time for parents with high levels of stress and emotional distress related to sleep deprivation and changes in family roles and relationships (Martins, 2018). The impact of pregnancy and parenthood on women's mental health (MH) is widely acknowledged (see Fisher et al., 2012 for review), as is the importance of the mother-child relationship. The fathers' role has been shown to have a different, yet equally important influence on a child's development (see Bretherton, 2010 for review). Recent literature suggests that fathers are also affected by mental health (MH) difficulties following the birth of a child, with prevalence rates of depression between 5-10% and anxiety between 5-15% (Leach, Poyser, Cooklin & Giallo, 2016; Paulson & Bazemore, 2010). It is clear that the transition to fatherhood can pose challenges and can impact upon fathers' emotional health and wellbeing, as well as mothers.

For those fathers who have care experience, the transition to parenthood may have an even greater impact on MH. Physical, sexual and emotional abuse in childhood is correlated with increased rates of depression, self-harm and suicide in adulthood (Thompson, Kingree & Lamis, 2018; Sachs-Ericsson, Stanley, Sheffler, Selby & Joiner, 2017). Given that up to 60% of children in care have experienced abuse and neglect either prior to or during their time in care (National Audit Office, NAO, 2015), individuals with care experience are likely to be vulnerable to poor outcomes in adulthood (Broad, 2005). Parental attachment quality is also associated with caregiving and the quality of the parent-child attachment (Psouni, 2019), which subsequently impacts upon MH outcomes for their children (Ranson & Urichuk,

2008). Despite increased MH difficulties in the postnatal period generally, and the increased prevalence of MH difficulties for individuals with care-experience, little research has been conducted to explore fathers' experiences during this time.

It is clear that care-experienced fathers have a unique journey that means that their transition to and through parenthood may be different to that of other fathers.

Through detailed exploration of these experiences, recommendations for supporting this population effectively may be sought.

### **Previous Literature**

Tyrer, Chase, Warwick and Aggleton (2005) explored the views of young fathers with experience of being in LAC. Sixteen fathers, aged 15-23, completed semi-structured interviews. Using a constant comparative method (Glaser & Strauss, 1967), authors identified that fathers felt socially excluded, experienced difficulties in trusting services and the mother of their child, and experienced multiple barriers to seeking support. Whilst this research is important, their lived experiences of fatherhood, in relation to their own childhood experiences, remained unclear.

Roberts (2017) investigated the experiences of care leavers who were parents in Wales using thematic analysis. She highlighted that parents feared their childhood experiences would have a negative impact on their parenting. When children remained in the care of parents, parenting offered an opportunity to heal from past experiences. This study was limited, however, as the participant sample focused

predominantly on mothers' experiences (7 mothers and 1 father). Weston (2013) also explored the lived experiences of mothers who had experienced the care system and similarly found that they expressed concerns about the impact of their previous experiences on their confidence with parenting. Weston described that mothers often felt that having a child provided a sense of purpose and achievement but feared whether their past experiences would impact on their children.

There has been more focus in the literature on motherhood and care-leavers' experiences of becoming mothers (Weston, 2013), particularly when women become parents in their teenage years (Connolly, Heifetz & Bohr, 2012; Pryce & Samuels, 2010). Fathers who have care experience, however, are frequently neglected in the research literature (Coleman, 2001).

### **Rationale for Study**

With the introduction of Shared Parental Leave (SPL) in 2015, which allowed fathers in the United Kingdom (UK) the opportunity to have longer paternity leave, fatherhood in general has received more attention (Kumar 2018; Kowlessar, Fox & Wittowski, 2015). Research highlighted that fathers frequently felt unsupported in adjusting to their role and felt marginalised by services despite their desire for information (Speak, Cameron & Gilroy, 1997a; Quinton, Pollock & Golding, 2002). Previous research has highlighted the importance of the father-child relationship in child development, however, there has been an emphasis within the qualitative literature on perceptions and attitudes towards fatherhood (Tyrer et al., 2005) rather

than how this population experience parenthood and the relationship with their child. Parents with care-experience have been shown to face additional challenges such as social exclusion and fear of stigma from services. Despite this, there remains a paucity of research focused on fatherhood from the perspective of care-experienced males. By exploring the lived experiences of fathers with care experience, these research findings can begin to provide a more in-depth exploration of this group.

### **Study Aims**

It is clear that the voices of fathers who have lived within the UK care system have been overlooked in research. Therefore, this study aims to qualitatively explore the lived experiences of fathers who have care-experience. It proposes the specific research question:

*What are the lived experiences of care-leavers who become fathers?*

### **Method**

#### **Research Design**

The epistemological orientation of this research is interpretivist, which assumes that our knowledge of reality is socially constructed and can be studied through individuals' use of language and shared meaning of experiences (Willig, 2001). Within this framework, Interpretive Phenomenological Analysis (IPA) was selected as an appropriate research design, as it facilitates exploration of lived experiences.



## Interpretative Phenomenological Analysis (IPA)

IPA examines how participants have made sense of their social world (Smith, Flowers & Larkin, 2009) and is particularly useful when studying under-researched areas (Eatough & Smith, 2006). It is underpinned by two main principles of phenomenology and hermeneutics (Smith et al. 2009). Phenomenological analysis provides a detailed and rich understanding of how a particular individual makes sense of a specific phenomenon, in a specific context (Husserl, 1927). Alongside a phenomenological exploration, IPA is an interpretative approach whereby the researcher is closely related to the data, as they attempt to make sense of the participant making sense of their experiences. This is known as the double hermeneutic cycle (Larkin & Thompson, 2012). It is the level of interpretation on the part of the researcher which distinguishes IPA from other approaches.

Several alternative research designs were considered, for example, Grounded Theory (Glaser & Strauss, 1967) or Discourse Analysis (Potter & Wetherell, 1987).

Grounded theory involves the development of a theory induced from collected data.

As in the current study, it can be usefully implemented when little is known about the topic area. It is limited, however, by the current research focus, which is to explore meanings made regarding participants' past experiences in care and becoming a parent. Discourse analysis focuses on how individuals construct their world using language and is appropriate when researchers wish to explore the language used in relation to specific psychological issues (Potter, 2003). The use of discourse analysis is not indicated for the current research as it does not examine an individual's lived experience, which is the primary focus here.

### **Sampling Design and Recruitment**

In line with the epistemological viewpoint of the research, a non-probability, purposive sampling strategy was employed. Purposive sampling is most commonly used in qualitative research to strategically select a sample based on certain criteria (Palys, 2008). This strategy produces a non-random sample of participants selected in accordance with inclusion and exclusion criteria to produce a homogenous sample (Table 1). Homogeneity is important in IPA to define a specific group for which the research question is relevant and meaningful (Smith & Osborn, 2008).

Table 1. Inclusion and Exclusion Criteria

<b>Criteria</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Gender	Male	Female
Age	Participant aged 18 + years	Participant aged below 18 years old
Experience of Care	Any Experience of Local Authority Care	No experience of Local Authority Care
Parenting Status	Has at least one biological child	Participant has no biological children
	Has contact with their child	No contact with child
Mental Health Status of Father	Participant is not currently experiencing significant mental health difficulties	Participant currently experiencing significant mental health difficulties
	No involvement with Child Protection Services	Involvement with Child Protection services
Health of Child	Child does not have diagnosed learning difficulty or neurodevelopmental condition	Child has diagnosis of learning difficulty or neurodevelopmental condition

The inclusion criteria specifies adult male (age 18 +) participants with at least one biological child. Although it is recognised that the term ‘father’ is broad and can encompass non-biological as well as biological parents, research has highlighted the unique experiences of non-biological parents (Abelsohn, Epstein & Ross, 2013),

therefore, for the purposes of creating a homogenous sample this study focused on biological fathers only. Young fathers (age <18 years) were excluded owing to further complex dynamics that exist for this population (Tyrer et al., 2005). Due to the 'hard-to-reach' nature of this population, an upper age limit was not set. Inclusion criteria were informed by previous literature (Weston, 2013) and allowed for a larger potential sample; important within a population that can be difficult to recruit (Doyle, Weller, Daniel, Mayfield & Goldston, 2016). It was specified that fathers must be in regular contact with their children in order to be able to reflect on the parent-child relationship. Fathers experiencing significant MH difficulties and children with learning difficulties or neurodevelopmental conditions were excluded as these have also been shown to impact upon the parent-child relationship (Ramchandani & Psychogiou, 2009).

Participants were recruited through a third sector charitable organisation providing support for adults with care-experience. Recruitment methods included advertisements in the charity newsletter, social media pages and word-of-mouth. Interested participants were asked to contact the researcher via email, where they received an information sheet (Appendix H).

Five fathers were recruited to participate in the study. This is in line with the recommended sample size within IPA studies (Thompson, Larkin & Smith, 2011), particularly when interviews demonstrate a depth and level of insight whereby

meaningful analysis can be completed and where the sample population is considered 'hard-to-reach' (Hefferon & Gil-Rodriguez, 2011).

### **Interview Schedule**

Each interview was guided by an interview schedule (Appendix I) developed in line with current research. Professionals involved with the charitable organisation reviewed the interview schedule to ensure that questions were sensitively phrased and accessible.

Questions were developed on the basis of general themes emerging from the existing evidence base. Weston (2013) and Roberts (2017) both reported that mothers feared the impact of their childhood on their offspring and reported being motivated to 'be better' than their parents. It was felt this theme was important to explore within the current study. Parents' hopes and fears were common themes in previous research, therefore, this theme was also incorporated into the interview guide. The schedule outlined a number of open-ended questions (Willig, 2001) used as a guide to allow any unexpected topics to be explored flexibly.

### **Data Collection**

Convenient interview dates were arranged with all participants who met the criteria and consented to participate ( $n=5$ ). Interviews were conducted face-to-face ( $n=2$ ) in locations as close to the participants home as possible. Where this was not possible, telephone interviews were completed ( $n=3$ ). Telephone interviews have been shown to produce data which is comparable in quality to face-to-face interviews (Carr &

Worth, 2001) and may even be preferable for accessing samples of fathers who are often difficult to reach (Kirsch & Brandt, 2002). Telephone interviews may also allow participants to feel more relaxed and encourage the discussion of more sensitive information (Novick, 2008). Interviews lasted between 46 and 91 minutes (Mean length = 68.2 minutes).

Prior to interview, participants were asked to review the information sheet and were given an opportunity to ask further questions. Written consent was gained from each participant and they were informed of their right to withdraw. Where telephone interviews were conducted, information sheets were sent via email. At the start of the interview, participants were reminded of key information and were asked relevant demographic questions (Appendix J). Interviews were digitally recorded and transcribed verbatim. All transcripts were anonymised, and pseudonyms allocated to protect confidentiality.

The use of semi-structured interviews is common practice in qualitative research (Lyons & Coyle, 2016). It is particularly advantageous in IPA, as it allows detailed exploration of themes discussed by participants. The second benefit of this method is that it provides the researcher with a guide based on previous literature, whilst allowing flexibility to develop rapport between researcher and participant.

### Description of Participants

Five participants completed semi-structured interviews. Participant ages ranged from 25-66 years ( $M=41$  years) and all fathers reported being UK born with English as their first language. Participants spent between 7 and 14 years in LAC and had between one and twelve placements. Four participants provided an approximate or unknown number of Local Authority placements as their memory was unclear (Table 2).

Table 2. Participant Demographics

Participant Pseudonym	Age	Age at First Placement	Total Length of Time in Care (years)	No. of Local Authority Placements	No. of Biological Children	Age of Children (years)
Peter	66	2	14	Unknown	5	21-45
David	33	6	11	Unknown	4	4-11
John	25	13	9	1	1	2
Paul	44	10	8	8*	4	5-20
Ashley	37	Birth	7	12*	2	0-17

\*approximate

### Data Analysis

Data was analysed using a framework proposed by Smith, Flowers and Larkin (2009) which included four main stages: initial reading of transcripts, identification and labelling of themes, identifying thematic clusters, and production of superordinate themes across transcripts (Pietkiewicz & Smith, 2014). Each interview was analysed fully before progressing to the next. Immediately following transcription, transcripts were re-read whilst listening to the original recording to

ensure accuracy. As outlined within the ethical procedure and Participant Information Sheet, audio recordings were then deleted. Transcripts were then re-read allowing the researcher to become immersed in the data, and initial thoughts were recorded in a research journal to enhance reflexivity. As recommended by Smith et al. (2009), each transcript was coded at three levels – descriptive, linguistic and conceptual – with each level of commentary providing a more in-depth understanding of the data. Descriptive annotations were based on the researcher's initial responses to the participants' thoughts and experiences. The second level of annotation – linguistic – commented on the use of language, such as use of metaphor or repetitions. Finally, the transcript was annotated on a conceptual level. At this stage, focus moved towards how the participants made sense of their experiences (see Appendix K for example of analysis). Following annotation of the transcripts, emergent themes were developed. Themes were compared across cases to highlight *convergence* and *divergence* between accounts and to produce superordinate and subordinate themes (Smith et al., 2009). For ease of analysis, emergent themes for each participant were hand written onto different coloured paper to create a visual map of subthemes and superordinate themes (Appendix L).

### **Validation Checks and Reflexivity**

Given that IPA involves a degree of interpretation on the part of the researcher, attempts were made to enhance credibility of the analysis (Smith, 2010). To ensure that interpretations were an accurate reflection of participants' experiences, a summary of themes was sent to respondents following analysis (see participant response in Appendix M). An interview extract was also coded by a second,



independent, researcher (Appendix N) and themes discussed to ensure they were grounded in the data.

As recommended, the research team conducted bracketing interviews prior to data collection to promote awareness of biases which may impact upon analysis (Finlay & Gough, 2008). The principal researcher also maintained a reflexive journal throughout (Smith, 2007) to explore the impact of being a childless, female researcher with professional experience of working with looked-after children. As a result of the bracketing interviews, I became aware that I was expecting fathers to have negative experiences of support services and to discuss emotive and distressing issues. To prevent the research holding a bias towards negative experiences I used supervision with the research team to allow these experiences to be balanced with the positive experiences that participants also described.

### **Ethical Considerations**

The research was approved by the Coventry University Ethics Board in January 2018 (Appendix O) and conducted in line with relevant professional codes of conduct, such as the British Psychological Society Code of Ethics and Conduct (BPS, 2009).

A number of ethical issues were considered throughout this study. The Code of Human Research Ethics (BPS, 2010) highlights issues such as respect for the dignity of persons, scientific value, social responsibility, maximising benefit and minimising harm. The primary concern whilst conducting this research was that of the potential

harm of discussing sensitive and emotive topics of parenting and adverse childhood experiences which may be traumatic for participants. This was addressed by ensuring that all participants were fully aware of their right to withdraw from the study at any time. Debrief information was provided following interviews that highlighted further sources of support. Furthermore, participants were recruited via a third sector organisation where they could access support.

Respect for participants and social responsibility were considered throughout. Informed consent was gained from all participants. Prior to their participation, participants were provided with an information sheet detailing the requirements at each stage (Appendix H). Respondent validation was used to ensure that the interpretations made by the researcher were an accurate reflection of the participants' views. Finally, the research findings will be disseminated to participants and the organisation involved to ensure that the findings are purposeful.

The impact of the study on the principal researcher was also considered; regular research and peer supervision was arranged throughout the duration of the study.

## **Findings**

### **Main Findings**

The aim of this study was to qualitatively explore the lived experiences of fathers with care-experience. Through analysis of interview data in accordance with IPA

principles, three key superordinate themes emerged; *‘Going Back to Move Forward’*, *‘Reliving the Past’* and *‘Breaking the Cycle’*. Each superordinate theme consisted of subordinate themes which were titled with verbatim quotes from participants (Table 3).

Table 3. Superordinate and Subordinate Themes

<b>Superordinate Themes</b>	<b>Subordinate Themes</b>	<b>Contributors</b>
Going Back to Move Forward	“Mad, sad and bad” “I learned to be guarded” “All that I wanted to achieve in life was normality”	All participants
Reliving the Past	“Eyes are always on me” “It’s like me being a kid again”	All participants
Breaking the Cycle	“I can see what I don’t want to be” “It’s the one thing I’ve done right” “I’ve found my place”	All participants

### **Going Back to Move Forward**

Throughout the accounts, it was common for participants to describe their experiences of parenting by initially describing their own childhood experiences and the impact of this on their self-identity and relationships. This enabled their parenting experiences to be placed into context. It appeared important for participants to express their narratives, indicating a sense of shame or fear of judgement relating to their past experiences:

“Interviewer: *How are you getting on [being a parent of a new born baby]?*”

Ashley: *Well to be honest, it has to go back quite a while.*” (Ashley)

The superordinate theme of ‘*Going Back to Move Forward*’ consisted of three subordinate themes; “*Mad, Sad and Bad*”, “*I’ve learned to be guarded*” and “*All that I wanted to achieve in life was normality*”.

### **“*Mad, Sad and Bad*”**

Three participants specifically reflected on the negative impact being in care had on their self-identity. Peter, David and Ashley all described having a negative view of themselves, for example, Ashley reported that he believed that he was “*damaged goods*” (Ashley) whereas Peter described frequently being told that he was “*bad*”, which left him feeling hopeless:

*“Every time I ran away, they told me I was bad and the more I did it they told me I was really, really, bad and the label mad, sad and bad label hung heavy around my neck.”*

(Peter)

Peter emphasised the stigma and weight of being in care; the label “*hung heavy*” around him. This highlighted the lasting impact that these experiences had on Peter’s views of himself and is suggestive of a high degree of shame experienced by Peter which he has carried with him for his whole life. The participants’ narratives indicated a sense of self-blame, suggesting that the participants believed the reason

for their adverse childhood experiences was intrinsic rather than as a result of external factors.

Ashley also described how “*running away*” was a strategy he developed in order to cope and escape from situations when he wasn’t believed by adults:

*“They didn’t believe me, home life was bad. I would tell the school, they wouldn’t believe me and I was literally dealing with everything myself and I started running away from home.”*

(Ashley)

These experiences of not being listened to or believed resulted in social isolation for participants. All participants described feeling alone throughout their childhood. David described needing to “*survive on my own*”, whereas Peter likened his experience of being lost and alone to that of a stray animal:

*“I became a sort of feral child, [...] like a feral cat, who can live out there and scrounge and get by.”*

(Peter)

Peter’s lack of belonging ultimately resulted in him feeling unwanted and unloveable, as reflected later in his narrative:

*“It feels like you have been abandoned. It feels like you are cast adrift [...] it feels like nobody loves you and it feels like it’s all your fault.”*

(Peter)

These adverse early experiences led participants to engage in a range of behaviours in adulthood in order to cope with feeling “*damaged*”, including offending

behaviours and drug and alcohol abuse, which further strengthened the participants' views of themselves as *"mad, sad and bad"*.

### ***"I learned to be guarded"***

All participants described experiencing inconsistent relationships with adults throughout childhood, resulting in them finding it difficult to trust others. David described taking relationships with *"a pinch of salt"*. Similarly, Peter and John reported that their early experiences had a negative impact on their ability to trust others:

*"It's hard to trust when you have been hurt so much in the past."* (John)

*"After a while, I think I just made up my mind. I'm not sure whether I can trust this person to stay around."* (Peter)

These experiences of frequently being abandoned impacted upon participants' style of attachment. The participants formed templates of relationships which suggested that relationships were temporary and, perhaps, futile. John used the phrase *"negative resilience"* to describe the mistrust that he felt towards others as a child. He described how his experiences of being continually let down left him feeling unable to emotionally connect with others:

*"You are so used to bouncing back and moving on that that's all you ever do, so you don't let other people in because you don't wanna get hurt again."*

(John)

All participants described how repeated experiences of being hurt and abused and/or being frequently moved to different placements resulted in ways of managing which ultimately led to further isolation:

*“I learned to be guarded, I learned to, you know, I’ve got my bubble. I’ve got my world in my head.”* (David)

The word “*bubble*” suggests that David kept his distance from people in order to protect himself. It may also suggest fragility, as if relationships could be popped and end at any moment. Paul described how his experiences of being “*let down by the system all my life*” resulted in him needing to become more self-reliant:

*“If your foundation is right, then everything above it will grow right...erm...and I’ve put that into myself from a very early age.”* (Paul)

Paul’s account of being consistently let down by adults around him has resulted in him finding his own “*foundation*” rather than relying on others to provide him with a solid basis for childhood development.

Within the interviews, mistrust within relationships was a prominent theme with a lasting impact on all participants. There was a shared experience of participants having to develop strategies to protect themselves, which resulted in them not emotionally investing in relationships. At times, they actively “*destroyed*” (Ashley) relationships as a means of self-protection and exercised caution and cynicism when

others wanted to form relationships with them. Participants reflected on the negative consequences of this style of relating to others and all wished to provide their children with a different experience.

***“All that I wanted to achieve in life was normality”***

Ashley, Paul and Peter all reflected on their desire to create a family in order to create a sense of belonging and normality. They described their experiences in care as being “*solitary*” (Paul) and lonely, in contrast to being part of a family which provided a sense of acceptance and belonging:

*“Your family is your lock around you, you know what I mean, and everyone has their part in that lock and if a part of that lock is missing, then it’s unlocked in a way.”* (Paul)

Paul’s metaphor of a family being a “*lock around you*” also indicated an increased sense of safety and security that perhaps he had not previously felt.

Whereby Paul and Peter had not planned their first children, Ashley’s experience was slightly different. Ashley expressed a wish to become a father as he felt that having a child was a way of creating a feeling of belonging and not being alone:

*“If I were to be honest, I was looking to belong somewhere.”* (Ashley)



For Peter, the wish to recreate a family unit was expressed throughout his narrative as he described wanting to provide a “mummy” for his daughter. This highlighted the importance that Peter placed on being part of a family. As he was deprived of this in his own childhood, he had a strong desire to provide this for his daughter.

All participants described that having a child and a family allowed them to feel like they fitted in with others which was synonymous with happiness:

*“I’d never been happy and that is all that I wanted to achieve in life is...was that normality, erm, having that normal lifestyle.”* (Paul)

### **Reliving the Past**

The second superordinate theme that emerged from the data was that of ‘*Reliving the Past*’, whereby all participants described how parenthood reminded them of past experiences. This encapsulated two subordinate themes; ‘*Eyes are Always on Me*’ which describes reliving the fear and mistrust of their childhood and ‘*It’s like me being a kid again*’ which focuses on the positive experiences gained throughout parenthood which were not experienced in their own childhoods.

#### ***“Eyes are always on me”***

All participants shared that, due to their past experiences, they feared judgement from others and had an overwhelming sense of feeling suspicious about

professionals. Participants highlighted that the stigma of being in care meant they felt under scrutiny from services by virtue of being in care themselves:

*“I’m constantly aware because of my history that eyes are always on me. I’m constantly aware that it only takes half an inch, one mistake, not even that, and life can change very, very dramatically. [...] I’m just constantly aware that there’s a potential of the kids being taken away.”* (David)

David described that his life and his family situation felt precariously balanced and could be changed at any moment. David’s account reflected an intense fear, and perhaps suspicion, that his children could be taken away from him even if he did not make any “*mistake*”. This may relate to David’s early experiences of not feeling in control of his life and being moved through multiple care placements without explanation, as John described in his narrative:

*“I think when you’re a kid that’s taken into care you lose all form of control.”* (John)

Ashley added to David and John’s accounts by making clear links between his fears of his children being removed from his care with his own childhood experiences:

*“From being in care you never know when something is going to be taken away from you.”* (Ashley)

It is clear from the narratives of David, John and Ashley that not feeling in control presents an intense threat that links to past experiences. They reflected that becoming

a parent, and having another person who they care for, placed them in a vulnerable position of feeling out of control. Participants described managing this through expressing positive aspects of parenting and not acknowledging more challenging aspects for fear of negative judgements, which could result in the removal of their children. Peter described needing to prove that he was an “OK Dad”) and reflected *“it’s very difficult to prove that you’re innocent”*.

Participants also feared judgement from others, which perhaps resulted in them going to additional lengths to prove that they were good parents. John described feeling a pressure to provide his child with a *“childhood every child should have”*. This pressure to provide a perfect childhood was also discussed by David and Paul who wanted to give their children material possessions, such as toys and computer games:

*“You want to see how many toys these kids have, I mean Christ, [name] is 8 years old, she has an iPad.”* (David)

Peter, however, was unable to provide material possessions for his daughter:

*“It would have been lovely to give her fantastic toys and all of that sort of stuff but what she didn’t get we made up for it in time.”* (Peter)

This illustrates how Peter felt the pressure to be able to provide financially for his family and how David, Paul and Peter all felt that the ability to provide material

goods for their family was a part of their role that provided a mark of their success as a parent.

John acknowledged that as his children have got older he does not feel *“like I’m looking over my shoulder all of the time now”*, which suggests that as John has had positive experiences of being a father, his fear of negative judgement from others has diminished.

Whereas Peter, David, John and Ashley described being fearful of their children being removed by Social Services, Paul described feeling anxious about when his children are older and develop romantic relationships:

*“It will be challenging for me because I sort of feel like I’m losing them.”*

(Paul)

Paul’s concerns highlight how his self-worth is maintained through his value as a parent and being wanted and needed by his children. Paul’s account indicated that as his children depend upon him less he may feel rejected and unwanted, perhaps mirroring his own childhood experiences.

Similarly, David and John reflected on how they initially felt concerned about being rejected by their baby, which impacted on their ability to bond:

*“I struggled to attach to her a little bit or I think she struggled to attach to me, but I think that was my own kind of insecurity really, erm, just thinking that I want to be the best Dad that I can be but I started to judge myself a little bit, thinking why does she want to spend so much time with her Mum.”*

(John)

David also described feeling *“almost like a third wheel”* and reported feeling excluded from the relationship between his partner and their baby, which resulted in him doubting his parenting skills:

*“You’re the odd one out, it’s like, what am I doing here? Am I doing the right thing?”*

(David)

Within most of the interviews, when participants were discussing difficult experiences, narratives became incoherent and fragmented. When asked about how many care placements they had experienced, Peter, David, Paul and Ashley were unclear. The fragmented and unclear life stories of participants may further impact on their self-identity and reflect trauma relating to past experiences. This is often seen in an incomplete and fragmented narrative:

*“The way my childhood memories kinda work are...it’s almost like somebody who’s suffered amnesia but, kinda, flashbacks.”*

(David)

This illustrates how the traumatic nature of participants’ early experiences have resulted in a lack of memory which may be protective.

***“It’s like me being a kid again”***

Peter and Paul described how having children allowed them to experience a childhood that they did not have, providing them with pride and satisfaction:

*“It’s putting things in place that I didn’t have or that I didn’t experience...it’s like me being a kid again. It’s like me having a childhood, which obviously I didn’t have.”* (Paul)

*“It was an opportunity to have a bit of a childhood myself...to be playful ‘cos I didn’t have much play.”* (Peter)

For Paul, the opportunity to experience situations with his children helped to compensate for childhood deprivation:

*“The care system ruined me, they stole my childhood away from me.”* (Paul)

Going back and reliving their own childhoods indicated the restorative power of being a parent for the participants. The accounts reflected the importance of play for child development and highlighted that this was a crucial element missing from their own childhoods. Participants reported frequently being motivated by their own needs, and parenting in line with what they would have wanted as children:

*“I respond to my daughter by thinking this is what I would want so I hope this is what she wants too.”* (John)

## **Breaking the Cycle**

The final theme to emerge from the interviews was that of '*Breaking the Cycle*'.

Participants reported a cycle whereby they had been abused and treated poorly by their parents and professionals caring for them. Participants were, therefore, keen to parent their children in a different way in order to break this cycle. Within this superordinate theme, three subordinate themes arose; "*I can see what I don't want to be*" in terms of parenting, how parenting was "*the one thing I've done right*" and how becoming a father changed participants' identities, allowing them to feel that "*I've found my place*".

### ***"I can see what I don't want to be"***

Ashley, Paul, John and Peter all talked about wanting to be different to their own parents. Participants reflected on experiences of being parented both by their parents and by care professionals. Both Ashley and Peter talked about knowing "*what I don't want to be*" (Ashley) in relation to the type of father they wanted to be and attempted to parent through doing "*the opposite of what I saw*" (Peter). From their accounts, it appeared that they found it challenging to parent in this way without having any positive model of parenting. Paul added to Ashley and Peter's narratives by stating that "*I never really seen what love was*" (Paul). This suggests that it is the emotional expression of love that Paul found difficult, as he had no model or template. However, despite not receiving this himself, Paul clearly valued this as an important part of parenting. Paul reflected that he had framed this in a positive light

as parenting “*from scratch*” had provided him with an additional sense of reassurance and achievement:

*“The influence that I put in my children is from me [...] it’s not from anybody else, it’s not mirrored anybody else, it’s just me, which I, I like that.”*

(Paul)

Paul’s narrative highlighted again the mistrust felt towards others and reflected his preference for self-reliance to adequately protect his children. It further highlights how parenting has boosted Paul’s self-worth, as he provided these experiences for his children.

John described a strategy whereby he provided his children with “*all of the experiences that I would have wanted my dad to give me*”. For John, this related to taking his children on holiday, whereas for Peter, this drew on his limited memories of being with his own dad, for example,

*“I have only got a very sketchy memory of my dad because I was really young when he, when he was gone, er, but the things I remember are riding on his shoulders.”*

(Peter)

and,

*“When she got tired, she sat on my shoulders and we walked.”*

(Peter)



***“It’s the one thing I’ve done right”***

Participants talked about how they experienced a sense of pride and achievement when raising their children. Ashley reported that when his children achieved in school, he also felt a sense of achievement:

*“Seeing them grow from something and knowing that you’ve helped them become that, especially when people go ‘aww aren’t your kids lovely’, it’s like you’ve done something good.”* (Ashley)

This extract suggests that the praise Ashley’s children received has impacted positively on his self-image and self-esteem. David articulated how prior to having children, he held a negative view of himself which has become more positive since having children:

*“It’s the one thing I’ve done right. In 33 years of being on this planet, I don’t ever see that I’ve done much right with my life. [...] you know being a father, creating a life, it is the be all and end all to me.”* (David)

David’s comments also reflect the importance of his children to him, suggesting that he couldn’t exist without them and his identity is focused on being a father. Paul and Ashley also described how being a father was a privilege that brought them a sense of pride and happiness:

*“I was excited and happy in the sense of achieving something that, is [...] not everybody can be a parent.”* (Paul)

*“As long as you’re calling me ‘Dad’ I’m doing something right.”*

(Ashley)

***“I’ve found my place”***

Participants described that being a father has had a positive impact on their life as they feel accepted by their partner and children:

*“I feel like I’ve found my place in terms of being a dad.”*

(John)

Becoming a father has also added some safety and stability into their lives that were missing from their own childhood:

*“I’ve never had that element in my life or that stability in that sense so me putting in that foundation when it, to becoming a father and stuff like that, I’ve not looked back.”*

(Paul)

Paul highlighted that he has not “*looked back*” and does not regret becoming a parent. This may also refer to Paul feeling that becoming a father has enabled him to move forward with his life and has allowed him, to some extent, to resolve his past traumatic experiences.

David also described that becoming a father has helped him to develop a more positive self-identity, which has impacted upon his view of others:

*“I wasn’t open back then. I didn’t trust anybody like that back then.”*

(David)

This quote highlights how, for David, becoming a father has provided a corrective relationship in which he has been able to trust and not been let down. This has ultimately had a positive impact on his ability to trust in the good intentions of others.

Ashley described how becoming a father has provided him with a feeling of acceptance and belonging:

*“Most people push you away if you get like I was but she [partner] accepted it so [...] yeah and the step-kids to be honest. They, they like doted on me, [...] they accepted me for who I was as well. So, I think that kind of helped too, yeah.”*

(Ashley)

Within interviews, participants suggested that becoming a father provided them with a purpose and meaning to their lives which was not there before:

*“David: The one thing I’ve given this world is my kids.*

*Interviewer: And what does that mean to you?*

*David: It means I’m not totally useless. In the grand scheme of things, I guess I do have a purpose.”*

(David)

## Discussion

This study sought to explore the lived experiences of fathers with care experience, giving fathers a voice in a research area that is often overlooked. To the best of the author's knowledge, this study provides the first in-depth insight into the experiences of fathers who were placed in LAC as children. Overall, three superordinate themes emerged from data collected from five participants; '*Going Back to Move Forward*'; '*Reliving the Past*' and '*Breaking the Cycle*'.

'*Going Back to Move Forward*' captures how fathers' experiences of parenting are closely linked to their own experiences of being parented. The current study is the first to identify how fathers find it necessary to explain their past in order to put their parenting experiences into context. Incorporated within this superordinate theme were three subordinate themes highlighting how fathers held negative views of themselves, perpetuated by frequently having their trust in relationships abused. The subordinate theme of '*I've learned to be guarded*' illustrated the impact of care on fathers' attachment style. Participants described a way of relating to others where they preferred to be self-reliant rather than depend others to provide safety and comfort. This mirrors an insecure, avoidant attachment style (Ainsworth, 1967) and supports previous research indicating that children exposed to abusive and neglectful experiences are more likely to be self-reliant within relationships (Bifulco, Jacobs, Ilan-Clarke, Spence & Oskis, 2016). When fathers require support with parenting, this style of relating may be challenged, potentially impacting on fathers' mental health and their willingness to seek support.

The theme of '*Reliving the Past*' highlighted how fatherhood prompted the re-experiencing of both positive and negative experiences. Participants described how childhood experiences of relationships ending led to fear that this would be repeated within the parent-child relationship. Previous research has found that fathers with care experience feel stereotyped as uncaring and often mistrust social services (Pollock, 2001; Tyrer et al., 2005). The current study extends this knowledge by highlighting that as a result of their early childhood experiences fathers may in fact be fearful of their children being removed from their care by social services. These findings suggest that fathers attempt to manage their fear by understating the challenges of parenting, which may be perceived as uncaring and mistrustful by professionals. This fear of judgement may result in care-experienced fathers being less likely to seek support and emphasises the dilemma faced by parents with histories of care, where they are keen to demonstrate that they can meet the challenges of parenting and manage their discomfort and anxiety to seek support when necessary (Rutman, Strega, Callahan & Dominelli, 2002). This constant fear of being perceived as incompetent or not coping with the demands of parenting may increase the pressure on care experienced fathers to be self-reliant and not access support which may enhance feelings of isolation. Social isolation and stigma of help-seeking are risk factors in perinatal mental health difficulties (Kawachi & Berkman, 2001; Doherty & Kartalova-O'Doherty, 2010). These findings therefore suggest that the risk factors present for all fathers may be exacerbated for fathers with care-experience.

Fatherhood also represented opportunities for participants to relive experiences that they did not have in their own childhoods. The opportunity to experience significant developmental stages, such as play, alongside their children was acknowledged as important by fathers. Play is a crucial part of child development enabling children to learn about themselves and the world, promoting cognitive and emotional development (Ginsburg, 2007). This study found that care-experienced fathers missed aspects of play and exploration as children but confirms their ability to recognise its importance and suggests that having these experiences alongside their children can have a restorative impact.

The third superordinate theme of *'Breaking the Cycle'* acknowledged participants' determination to provide a different style of parenting from their own. This was of benefit to both parent and child. Parenting has been identified as a protective factor against offending behaviours (Reeves, Gale, Webb, Delaney & Cocklin, 2009). Current findings support this literature and suggests that the protective mechanism of fatherhood is two-fold. Participants reported that being a father provided them with a feeling of determination to provide their children with a different childhood to the one that they experienced, resulting in pride and achievement when their children succeeded. In addition, the acceptance and belonging experienced from being part of a family appeared to facilitate a change within fathers' negative views of themselves. The finding of wanting to break the cycle is similar to research conducted with mothers who also described a fear of their childhoods impacting on their parenting. Mothers found that being a parent provided a sense of purpose, achievement, belonging and stability (Roberts, 2017; Weston, 2013). The similarities between

mothers and fathers with care experience suggest that the impact of care produces shared concerns for parents regardless of gender.

Overall, fathers described a number of positives that emerged from their challenges, both in care and of parenting. It could be argued that fathers, in certain circumstances, undergo a process of posttraumatic growth. Posttraumatic growth is a concept which describes the positive changes that occur in response to highly challenging or traumatic life events (Tedeschi & Calhoun, 2004). It is a relatively new concept that has been met with some criticism (Christiansen, Iverson, Ambrosi & Elklit, 2015). However, it is suggested that posttraumatic growth can be facilitated through the development of narratives surrounding the traumatic experience/s, which occur when individuals feel safe and secure (Neimeyer, 2004). Fathers in the current study all had stable lifestyles and consistent support networks upon which they could draw.. Not all care-experienced fathers, however, have these stable support networks in place. Therefore, to facilitate posttraumatic growth in care-experienced fathers, increasing awareness of the impact of parenting on this population should be at the forefront in the development of services.

### **Clinical Implications**

This study provides an insight into how men with care experience make sense of fatherhood. Based on current findings, recommendations for effective support at both clinical practice and wider policy level can be made. There are clear links between fathers' own childhoods and their experiences of parenting. For fathers to feel valued

and understood, it is important to consider the context of their experiences.

Healthcare professionals may not be aware of fathers' histories and are, therefore, less able to address the specific needs of care-experienced fathers. Furthermore, fathers may fear judgement from professionals and be less likely to disclose difficulties or challenges. Those working within maternity and social care services should hold in mind the importance of asking fathers about early experiences and allow time for them to tell their life story, whilst demonstrating a non-judgemental stance to promote feelings of acceptance. Hearing fathers' narratives may help both professionals and fathers to understand their parenting behaviours more fully and allow interventions to be tailored to their specific needs. On a wider scale, these findings highlight the intergenerational impact of care experience and may also have important implications for those working in Adult MH services. The challenges faced by care-experienced fathers may form an integral part of an individual's trauma-focused therapy and warrant exploration as part of psychological intervention.

The feeling of belonging was reported to be an important and restorative feature of becoming a parent for care-experienced fathers. Participants described feeling isolated and alone prior to becoming a parent, which resulted in offending behaviours, drug and alcohol misuse and MH difficulties. There were multiple placement breakdowns throughout childhood and a lack of support when participants left care at 18. At a wider policy level, more support is required for those leaving care to promote feelings of inclusion, acceptance and belonging. One such way may be to establish community projects to provide fathers with opportunities to meet



others and develop parenting skills. Peer-led support networks can be effective for disadvantaged population groups (Ford, Clifford, Gussy & Gartner, 2013), providing positive role models and enabling fathers to share their unique experiences of 'breaking the cycle' of care. Such projects are currently being run locally by third sector organisations, however, they are not routinely offered by Local Authority services. Group programmes developed by charitable organisations also serve to provide fathers with ways of accessing those experiences they missed in childhood, such as play and the development of positive relationships. The building of emotional connections has been acknowledged as a key feature in reducing psychological distress in children, particularly in complex trauma presentations (Cook et al., 2005), and may also provide a framework for adults. These communities could also offer valuable support to male care-leavers who do not have children.

In the current study, reliving aspects of their childhood that were missed was described as a valued part of being a parent. Notably, participants reported the lack of support available to them throughout their lives. Based on the importance of fathers feeling accepted and being supported to construct their narratives, a range of psychological therapies may be particularly beneficial for this population. When further support is required, psychological therapies for fathers with care experience may need to be more creative by appropriately incorporating aspects of play. Wilderness therapies and community-based programmes are increasingly being recognised as an alternative approach to traditional therapeutic interventions for adolescents and may also offer benefits for care-experienced fathers (Russell, 2007).

Horticultural Therapy has also been shown to improve social and emotional outcomes in veterans transitioning to civilian life (Wise, 2018). Promotion of these community-based programmes for individuals with care experience may support the development of posttraumatic growth. Furthermore, acceptance and compassion-based therapies may have a positive impact on care-experienced fathers experiencing emotional distress. Such therapies have a good evidence base for use with trauma (Lee & James, 2012; Follette & Pistorello, 2007). Narrative therapies, specifically Attachment Narrative Therapy (Dallos, 2006), and Dyadic Developmental Psychotherapy (Hughes, 2004) may also support fathers who experience difficulties within the relationship with their children. Exploration of fathers' own attachment histories in a supportive, therapeutic relationship is likely to help fathers to develop more secure attachment relationships with their children.

### **Limitations and Directions for Future Research**

These findings offer the first in-depth exploration of the lived experiences of fathers who have experienced LAC. As well as providing a voice for a population that is frequently disadvantaged and socially excluded, this research highlights a number of clinical implications that can improve services for fathers with care experience. Despite these strengths, there are some limitations. Although IPA research is not concerned with generalisability, participants in this study were living (or had lived) with their children. Those fathers who are not resident with their children may have different experiences from those highlighted within this study. Care-experienced fathers experiencing severe MH difficulties, or those undergoing social care proceedings were excluded from the research. Therefore, future research may wish

to involve this population of fathers to compare and contrast their experiences with those of the current study. This would allow the development of clinical recommendations for a population who do not routinely access support services, arguably due to help-seeking stigma (Yousaf, Grunfield & Hunter, 2015).

There are some methodological limitations that should also be noted. Firstly, although there is no pre-determined sample size within qualitative research (Pietkiewicz & Smith, 2014), a sample size of five may be considered to be small for IPA studies and may be criticised for not providing the depth and richness required of data required. Attempts were made to recruit participants from a range of Care Leaver teams, Parenting Support teams and charitable organisations across the country, however, only five participants contacted the author to participate. Fears of judgement from researchers, lack of access to travel and childcare considerations may have prevented more individuals from participating within the study. As interviews were, on average, 68 minutes long and all participants explored their personal meaning-making and understanding of their experiences, it is argued that the resultant findings provide a starting point for exploring the experiences of a group of individuals who are often excluded within research (Doyle et al., 2016).

To ensure that the study was accessible to all eligible individuals who wished to participate, interviews were conducted either face to face or via telephone. Encrypted platforms to conduct interviews via video link were considered, however, participants did not consistently have access to the technology required. Conducting

interviews over the telephone, therefore, provided participants with a means to access the research in order to have their voice heard. Although telephone interviews have been suggested to be advantageous particularly when collected data on sensitive and emotive topics (Kirsch & Brandt, 2002), not being face to face with participants may have impacted on the relationship with the interviewer and prevented the researcher from using non-verbal information to explore participant experience fully.

Secondly, due to difficulties in recruitment, the ages of participants varied, thus, diluting the homogeneity of the sample. Despite variations in ages, all fathers had experiences of living with their children and having regular contact with their children. All fathers reported similar childhood experiences of Local Authority Care i.e. multiple placements within residential and foster care. Therefore, although varying in age, the experiences and family demographics of fathers were homogenous.

This study found that partners and children provided care-experienced men with feelings of acceptance and belonging which boosted their self-esteem, self-worth and supported in the development of a positive self-identity. Interestingly, children who have been adopted view friendships as providing a sense of safety, as well as being a source of anxiety (Wright, 2017). Exploration of how men who have LAC experience, rather than adoption, view friendships or romantic relationships would contribute valuable knowledge. This may shed light on how care-experienced men

without children can also feel accepted and a sense of belonging, impacting positively on their emotional wellbeing.

## **Conclusion**

Fathers outline a number of challenges to becoming a parent that are unique to those who have care-experience. Despite this, participants describe being a father as a chance to relive the childhood that they did not experience and to feel a sense of belonging and acceptance as part of a family unit. This, ultimately, appears to impact positively on fathers' views of themselves, moving from an identity of 'Mad, Sad and Bad' to 'Dad'. Most important to all fathers was the ability to break the cycle of care, in order to provide their children with experiences different to their own.

## References

- Abelsohn, K. A., Epstein, R. & Ross, L. E. (2013). Celebrating the “Other” parent: Mental Health and Wellness of Expecting Lesbian, Bisexual, and Queer Non-birth parents. *Journal of Gay and Lesbian Mental Health*, 17, 387-405. doi: 10.1080/19359705.2013.771808.
- Ainsworth, M. (1967). *Infancy in Uganda: Infant care and the growth of love*. Baltimore, MD: Johns Hopkins University Press.
- Bifulco, A., Jacobs, C., Ilan-Clarke, Y., Spence, R. & Oskis, A. (2016). Adolescent Attachment Style in Residential Care: The Attachment Style Interview and Vulnerable Attachment Style Questionnaire. *British Journal of Social Work*, 47, bcw117. doi: 10.1093/bjsw/bcw117.
- Bretherton, I. (2010). Fathers in attachment theory and research: a review. *Early Child Development and Care*, 180, 9-23. doi: 10.1080/03004430903414661.
- British Psychological Society, (2009). *Code of Ethics and Conduct*. Leicester, UK: British Psychological Society. Retrieved from: <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/Code%20of%20Ethics%20and%20Conduct%20%282009%29.pdf>.
- British Psychological Society, (2010). *Code of Human Research Ethics*. Leicester, UK: British Psychological Society. Retrieved from: <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf>.

Broad, B. (2005). *Improving the Health and Wellbeing of Young People Leaving Care*. Dorset: Russell House.

Carr, E. C. J. & Worth, A. (2001). The use of telephone interview for research. *Social Science Collections*, 6, 511-524. doi: 10.1177/136140960100600107.

Christiansen, D. M., Iverson, T. N., Ambrosi, S. L. & Elklit, A. (2015). Posttraumatic Growth: A Critical Review of Problems with the Current Measurement of the Term. In: Martin C., Preedy V., Patel V. (Eds.) *Comprehensive Guide to Post-Traumatic Stress Disorder*. Cham: Springer. doi: 10.1007/978-3-319-08613-2\_5-1.

Coleman, J. (2001). Focus: Young Fathers. *Young People's Health Network Newsletter*, 15, 1.

Connolly, J., Heifetz, M. & Bohr, Y. (2012). Pregnancy and Motherhood among Adolescent Girls in Child Protective Services: A Meta-Synthesis of Qualitative Research. *Journal of Public Child Welfare*, 6(5), 614-635. doi: 10.1080/15548732.2012.723970.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E. & van der Kolk, B. (2005). Complex Trauma in Children and Adolescents. *Psychiatric Annals*, 35(5), 390-398. doi: 10.3928/00485713-20050501-05.

Cowan C. P. & Cowan P. A. (2000). *When partners become parents: The big life change for couples*. Mahwah, NJ: Lawrence Erlbaum Associates.

Dallos, R. (2006). *Attachment Narrative Therapy: Integrating Narrative, Systemic and Attachment Therapies*. England: Open University Press.

Department of Health (2000). Children (Leaving Care) Act. *Department of Health*.

Retrieved from:

[https://webarchive.nationalarchives.gov.uk/20121206162732/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4058600.pdf](https://webarchive.nationalarchives.gov.uk/20121206162732/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058600.pdf).

Doherty, D. T. & Kartalova-O'Doherty, Y. (2010). Gender and self-reported mental health problems: Predictors of help-seeking from a general practitioner. *British Journal of Health Psychology*, 15, 213-228. doi: 10.1348/135910709X457423.

Doyle, O., Weller, B.E., Daniel, S.S., Mayfield, A. & Goldston, D.B. (2016). Overcoming barriers to fathers' participation in clinically relevant research: recommendations from the field. *Social Work Research*, 40, 260-264. doi: 10.1093/swr/svw015.

Eatough, V. & Smith, J. (2006). 'I was like a wild, wild person': understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*, 97, 483-498. doi: 10.1348/000712606X97831.

Finlay, L. & Gough, B. (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. Mahwah, NJ: Wiley.

Fisher, J., de Mello, M. C., Patel, V., Rahman, A., Tran, T., Holton, S. & Holmes, W. (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: A systematic review. *Bulletin of the World Health Organization*, 90, 139-149. doi: 10.2471/BLT.11.091850.



- Follette, V. & Pistorello, J. (2007). *Finding life beyond trauma: using acceptance and commitment therapy to heal from post-traumatic stress and trauma-related problems*. Canada: New Harbinger Publications.
- Ford, P., Clifford, A., Gussy, K. & Gartner, C. (2013). A Systematic Review of Peer-Support Programs for Smoking Cessation in Disadvantaged Groups. *International Journal of Environmental Research and Public Health*, 10, 5507-5522. doi:10.3390/ijerph10115507.
- Ginsburg, K. R. (2007). The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent Child Bonds. *Paediatrics*, 119(1), 182 – 191. doi: 10.1542/peds.2006-2697.
- Glaser, B.G. & Strauss, A.L. (1967). *The discovery of Grounded Theory*. Chicago: Aldine.
- Hefferon, K. & Gil-Rodriguez, E. (2011). Methods: Interpretative phenomenological analysis. *The Psychologist*, 24, 756-759.
- Heyman, R. E. & Smith-Slep, A. M. (2002). Do childhood abuse and interparental violence lead to adulthood family violence? *Journal of Marriage and Family*, 64, 864–870. doi: 10.1111/j.1741-3737.2002.00864.x.
- Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment and Human Development*, 6, 263-278. doi: 10.1080/14616730412331281539.
- Husserl, E. (1927). Phenomenology. For *Encyclopaedia Britannica* (R. Palmer, Trans. And revised). Available at: <http://www.hfu.edu.tw/~huangkm/phenom/husserl-britannica.htm>.

- Kawachi, I. & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health*, 78, 458-467. doi: 10.1093/jurban/78.3.458.
- Kirsch, S. E. D. & Brandt, P. A. (2002). Telephone Interviewing: A Method of Reach Fathers in Family Research. *Journal of Family Nursing*, 8, 73-84. doi: 10.1177/107484070200800105.
- Kowlessar, O., Fox, J. R. & Wittowski, A. (2015). The pregnant male: a meta-synthesis of first-time fathers' experiences of pregnancy. *Journal of Reproductive and Infant Psychology*, 33, 106-127. doi: 10.1080/02646838.2014.970153
- Kumar, S. V., Oliffe, J. L. and Kelly, M. T. (2018). Promoting Postpartum Mental Health in Fathers: Recommendations for Nurse Practitioners. *American Journal of Men's Health*, 12(2), 221-228. doi: 10.1177/1557988317744712.
- Lamb, M. E. & Lewis, C. (2010). The development and significance of father-child relationships in two parent families. In M.E. Lamb (Ed.), *The role of the father in child development*. Hoboken, NJ: Wiley.
- Larkin, M. & Thompson, A. (2012). Interpretative Phenomenological Analysis. In A Thompson & D Harper (Ed.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. Oxford: John Wiley and Sons. doi: 10.1002/9781119973249.
- Leach, L. S., Poyser, C., Cooklin, A. R. & Giallo, R. (2016). Prevalence and course of anxiety disorders (and symptom levels) in men across the perinatal period: A systematic review. *Journal of Affective Disorders*, 190, 675-689. doi: 10.1016/j.jad.2015.09.063.

- Lee, D. & James, S. (2012). *The Compassionate Mind Approach to Recovering from Trauma: Using compassion focused therapy*. UK: Hachette.
- Lyons, E. & Coyle, A. (2016). *Analysing Qualitative Data in Psychology*. UK: Sage Publications.
- Martins, C. A. (2018). Transition to parenthood: consequences on health and well-being. A qualitative study. *Enfermeria Clinica*. Advance online publication. doi: 10.1016/j.enfcli.2018.04.005.
- National Audit Office (2015). *Children in Care*. UK: Department for Education. Retrieved from: <https://www.nao.org.uk/wp-content/uploads/2014/11/Children-in-care1.pdf>.
- Neimeyer, R. A. (2004). Fostering Posttraumatic Growth: A Narrative Elaboration. *Psychological Inquiry*, 15, 53-59. doi: 10.1093/oxfordhb/9780199734610.013.0069.
- Novick, G. (2008). Is there a Bias Against Telephone Interviews in Qualitative Research? *Research in Nursing and Health*, 31(4), 391-398. doi: 10.1002/nur.20259.
- Oosterman, M., Schuengel, C., Forrer, M. L. & De Moor, M. H. M. (2019). The impact of childhood trauma and psychophysiological reactivity on at-risk women's adjustment to parenthood. *Development and Psychopathology*, 31, 127-141. doi: 10.1017/S0954579418001591.
- Palys, T. (2008). Purposive sampling. In L.M. Given (Ed.) *The Sage Encyclopaedia of Qualitative Research Methods*. (Vol.2). Los Angeles: Sage.

- Paulson, J. F. & Bazemore, M. S. (2010). Prenatal and Postpartum Depression in Fathers and Its Association with Maternal Depression: A Meta-analysis. *The Journal of the American Medical Association*, 303(19), 1961–1969. doi:10.1001/jama.2010.60.
- Pietkiewicz, I. & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal*, 20, 7-14. doi: 10.146991/CPPJ.20.1.7.
- Pollock, S. (2001) Young first-time fathers – influences on commitment. *Young People's Health Network Newsletter*, 15, 8.
- Potter, J. & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage.
- Potter, J. (2003). Discursive Psychology: Between Method and Paradigm. *Discourse and Society*, 14, 783-794. doi: 10.1177/09579265030146005.
- Pryce, J. M. & Samuels, G. M. (2010) Renewal and risk: the dual experience of young motherhood and ageing out of the child welfare system. *Journal of Adolescent Research*, 25(2), 205-230. doi: 10.1177/0743558409350500.
- Psouni, E. (2019). The influence of attachment representations and co-parents' scripted knowledge of attachment on fathers' and mothers' caregiving representations. *Attachment and Human Development*. doi: 10.1080/14616734.2019.1582598.
- Quinton, D., Pollock, S. & Golding, J. (2002) *The transition to fatherhood in Young Men: Influences on Commitment*. ESRC Report. Retrieved from:

<http://www.fatherhoodinstitute.org/2006/the-transition-to-fatherhood-in-young-men-influences-on-commitment/>.

Ramchandani, P. & Psychogiou, L. (2009). Paternal psychiatric disorders and children's psychosocial development. *Lancet*, 374, 646-653. doi: 10.1016/S0140-6736(09)60238-5.

Ranson, K. E. & Urichuk, L. J. (2008). The effect of parent-child attachment relationships on child biopsychosocial outcomes: a review. *Early Child Development and Care*, 178, 129-152. doi: 10.1080/03004430600685282.

Reeves, J., Gale, L., Webb, J., Delaney, R. & Cocklin, N. (2009). Focusing on young men: developing integrated services for young fathers. *Community Practitioner*, 82, 18-21.

Roberts, L. (2017). A small-scale qualitative scoping study into the experiences of looked after children and care leavers who are parents in Wales. *Child and Family Social Work*, 22, 1274-1282. doi: 10.1111/cfs.12344.

Russell, K. C. (2007). Brat camp, boot camp or ...? Exploring wilderness therapy program theory. *Journal of Adventure Education and Outdoor Learning*, 6, 51-67. doi: 10.1080/14729670685200741.

Rutman, D., Strega, S., Callahan, M. & Dominelli, L. (2002). 'Undeserving' mothers? Practitioners' experiences working with young mothers in/from care. *Child and Family Social Work* 7, 149–159.

Sachs-Ericsson, N. J., Stanley, I. A., Sheffler, J. L., Selby, E. & Joiner, T. E. (2017). Non-violent and violent forms of childhood abuse in the prediction of suicide

- attempts: Direct or indirect effects through psychiatric disorders. *Journal of Affective Disorders*, 215, 15–22. doi: 10.1016/j.jad.2017.03.030.
- Shaghaghi, A., Bhopal, R. S. & Sheikh, A. (2011). Approaches to Recruiting ‘Hard-To-Reach’ Populations into Research: A Review of the Literature. *Health Promotion Perspectives*, 1(2), 86-94. doi: 10.5681/hpp.2011.009.
- Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being*, 2, 3-11. doi: 10.1080/17482620601016120.
- Smith, J. A. (2010). Evaluating the contribution of Interpretative Phenomenological Analysis. *Health Psychology Review*, 5, 9-27. doi: 10.1080/17437199.2010.510659.
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.
- Smith, J. A. & Osborn, M. (2008). Interpretative phenomenological analysis. In Smith, J. A. (Ed). *Qualitative psychology: A practical guide to methods-second edition*. London: Sage.
- Speak, S., Cameron, S. & Gilroy, R. (1997a). *Young Single Fathers: Participation in Fatherhood – Bridges and Barriers*. London: Family Policy Studies Centre.
- Tedeschi, R. G. & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychology Inquiry: An International Journal for the Advancement of Psychological Theory*, 15, 1-18. doi: 10.1207/s15327965pli1501\_01.

- Thompson, A., Larkin, M. & Smith, J. A. (2011). Interpretative phenomenological analysis and clinical psychology training: Results from a survey of the group of trainers in clinical psychology. *Clinical Psychology Forum*, 222, 15-19.
- Thompson, M. P., Kingree, J. B. & Lamis, D. (2018). Associations of adverse childhood experiences and suicidal behaviours in adulthood in a U.S. nationally representative sample. *Child: Care, Health and Development*, 45. Advanced online publication. doi: 10.1111/cch.12617.
- Tyrer, P., Chase, E., Warwick, I. & Aggleton, P. (2005) 'Dealing with it': Experiences of Young Fathers in and Leaving Care. *British Journal of Social Work*, 35, 1107-1121. doi: 10.1093/bjsw/bch221.
- Weston, J. (2013). *Care Leavers' experiences of being and becoming parents* (Unpublished doctoral dissertation). University of Hertfordshire, UK.
- Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method*. Open University Press: Buckingham, Philadelphia, USA.
- Wise, J. (2018). *Digging for Victory: Horticultural Therapy with Veterans for Post-Traumatic Growth*. London: Routledge. doi: 10.4324/9780429473746.
- Wright, J. (2017). *How do children and young people who have been adopted experience peer relationships* (Unpublished doctoral dissertation). University of Birmingham, UK.
- Yousaf, O., Grunfeld, E. A. & Hunter, M. S. (2015). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review*, 9(2), 264-276. doi: 10.1080/17437199.2013.840954.

### **Chapter III: Reflective Paper**

#### **Not Knowing and Not Belonging: A Reflective Account of the Research Process**

Chapter Word Count: 3,079



## **Introduction**

This final chapter presents a reflective summary on the process of conducting research with care-experienced fathers. In this account, I consider the importance of reflection and reflexivity within qualitative research. By maintaining a research journal and completing bracketing interviews (Tufford & Newman, 2010), I have become aware of my own motivations for conducting research with care-experienced fathers. Here, I discuss my own biases, assumptions and preconceptions, highlight my position within the research and notice the not-knowing and not-belonging position of myself within the research process which appears parallel to the not-knowing and not-belonging positions described by the participants taking part in the research. I then move on to discuss the emotional impact of the research with reference to relevant psychological theory.

## **Reflexivity**

The process of critical reflection and reflexivity within research are essential to highlight the impact of the researcher on the process. Broadly speaking, reflection is the process of learning from experiences, which requires self-awareness at both cognitive and emotional levels (Schön, 1983). Reflection is widely acknowledged as an important aspect within clinical practice. Moreover, reflexivity is a complementary process of considering and understanding the impact of our own biases, preconceptions, values and assumptions on clinical practice (Mann, Gordan & MacLeod, 2009).

Prior to and during my training to be a Clinical Psychologist, I have found the application of reflection and reflexion to my clinical practice has allowed me to become aware of how my own values and experiences impact upon the therapeutic alliance. It has also prompted much personal growth and learning. The process of completing qualitative research was a new task for me and I found that reflection and reflexivity were of equal value to my development as a reflective-scientist practitioner. Bradbury-Jones (2007) highlighted the importance of reflexivity at all stages of the research process, from the development of a research question, through to data analysis and the drawing of conclusions. It is through the use of reflexion that a researcher can demonstrate the trustworthiness of the research process, thus enhancing the credibility of research findings (Cutcliffe, 2003). This is of particular importance in Interpretative Phenomenological Analysis (IPA). Central to IPA is phenomenological inquiry, which closely examines lived human experience. However, it is argued that this process is interpretative in nature. The task of analysis involves a double hermeneutic cycle (Smith & Osborn, 2003), which involves the researcher making interpretations related to how participants have made sense of their experiences. It is of critical importance, therefore, that the researcher is aware of their prior assumptions and biases in order to separate these as far as possible from the experience of participants (Smith, Flowers & Larkin, 2009). It is through engagement with this reflective process that I recognised some similarities between my position within the research and the experiences of participants.

## **Not Knowing, Not Belonging: My Research Position**

Prior to Clinical Psychology training, my research experience was predominantly quantitative. I recognised the importance and value of the quantitative research that I had conducted, however, I felt that there was a depth of knowledge and experience that was lacking. I felt frustrated by the reductionist, positivist stance that suggested that human behaviour could be explained by a single ‘truth’ (Hayes, 2000).

Although I had enjoyed completing quantitative research, I began to realise that the research areas in which I was interested focused primarily on people’s experiences and how individuals made sense of their internal, as well as external, worlds. At the same time, I began working as an Assistant Psychologist within a Looked After Children’s team. I was intrigued by the impact of early experiences on brain development and the cognitive, emotional and social consequences that adverse childhood experiences had on individuals. There was an abundance of quantitative research highlighting the negative outcomes for looked-after children as well as research suggesting that early trauma and abuse had an impact at an epigenetic level (Baradon, 2010), however, I found that I was left wondering about the experiences of this population – what was it like for looked after children and how did they make sense of their experiences?

When I came to select a research topic for the Doctorate in Clinical Psychology programme, the experiences of parents when they had not experienced consistent parenting themselves was an unanswered question for me that felt important to

explore in more detail. I was curious about the popular narratives and debates within the literature regarding intergenerational abuse. Some research suggested that parents who had experienced abuse and neglect in their childhoods were more likely to be the perpetrators of abuse and neglect towards their own children (Heyman & Smith-Slep, 2002). However, contrasting research and my own clinical experiences contradicted these narratives (Renner & Slack, 2006). Working with looked-after children and adults with adverse childhood experiences, I began to reflect upon my own experiences of childhood. I grew up in a working class family that was nurturing and supportive. Although I am not a parent, I noticed how I frequently referred to my own childhood and experiences of being parented as a model of interaction for the children that I was working with clinically. As suggested by Bowlby (1977), my early experiences and attachment style provided a 'blueprint' for my personal relationships and how I envisage parenting my own children. As a result, I began to wonder about individuals whose template for parenting is not one they wished to replicate and how individuals parent without such a 'blueprint'.

Although, the social constructionist perspective of qualitative research made sense to me intuitively, I had not previously conducted qualitative research and the thought of embarking on a qualitative research project at this level felt daunting. Research highlighted that qualitative research, specifically IPA, was the most appropriate approach for my research topic of exploring the lived experiences of individuals who had been looked-after as children. This placed me, somewhat uncomfortably, in a position of 'not knowing' and learning about the research process as I went along. As a result, I relied heavily on research and peer supervision, establishing an IPA

peer support group and reading all available literature in an attempt to relieve the feeling of ‘not knowing’.

It soon became clear that this position of ‘not-knowing’ was a more comfortable position than that of assuming knowledge. It allowed me to explore different perspectives on the process of conducting IPA research and to remain flexible and grounded within the data. This was similar to the process of personal development that I had experienced clinically where, as a clinical practitioner early in training, I wanted to know the answers and the ‘correct’ way of delivering therapeutic interventions. Similarly to my development as a therapist, as a researcher I have moved from a position of ‘unsafe uncertainty’ to ‘safe uncertainty’ (Mason, 1993) whereby I began to feel more comfortable in collaboratively delivering therapeutic interventions and, in the case of the research process, being led by participants. This learning was particularly evident when conducting interviews, whereby a researcher should be guided by the content brought by participants rather than their own preconceptions. From these experiences, I drew parallels between my own discomfort about ‘not knowing’ in relation to the research process, and how this may feel for participants who reported to have had experiences of ‘not knowing’ throughout most of their childhoods.

As a researcher, I have also reflected upon my positionality within the research. Positionality has been described as the social location of the researcher in relation to the population being researched (McCorkel & Myers, 2003). As a female researcher,

who is not a parent and was not in Local Authority Care throughout my childhood, I have been aware of my different life experiences throughout the research process. It has been argued that one cannot complete research without being part of the population being studied as the researcher is unable to identify with points of reference (Fawcett & Hearn, 2004). Not belonging to the population being researched did present some challenges, as participants were initially unsure of my motivations and participants asked about why I had chosen to research this topic.

Furthermore, it is possible that this made the recruitment of participants more challenging as they were suspicious of my motivations. On the whole, however, I felt that not belonging and being an ‘outsider’ (Berger, 2015) also provided me with advantages. Throughout the research process, I felt able to assume a non-expert role, putting participants in the position of expert and offering an empowering experience for a group of fathers who frequently reported not being heard or acknowledged by society. This is an argument echoed in other literature (Berger & Malkinson, 2000; Berger, 2015).

As the research progressed and I began collecting and analysing data, I feel that I moved from an ‘outsider’ position to a partial ‘insider’ position (Berger, 2015) as I moved around the double hermeneutic cycle (Smith & Osborn, 2003). Prior to data collection, I engaged in bracketing interviews (Tufford & Newman, 2010) which highlighted my existing assumptions relating to fathers with care-experience. I reflected on the biases I held with regards to participants’ life experiences and how I

assumed that the majority of fathers would have difficulties within relationships. Through acknowledgement of these preconceptions, I put these to one side in order to become fully immersed in the participant experience during interviews. I noticed that participants' stories contained more hope than I had expected and following each interview I noticed an increased connection with participants. As described by Smith (2007), engagement with this process left me "*irretrievably changed*" (p.6). As I moved around the double hermeneutic cycle and my understanding of participants' experiences developed, I felt that I became more of an 'insider' which had a lasting emotional impact on me.

### **'Ghosts' in the Research**

Given the relational focus of the research, I looked towards psychodynamic theory to reflect on my experiences and the emotional impact of the research process. I was aware that researching the topic of parenting was likely to be emotive and was expecting to reflect on how my own childhood experiences represented a stark contrast to the experiences of participants. However, I was less prepared for the emotions brought up within the relationship with participants and with the research itself. Documenting my experiences in a reflective journal encouraged me to pay particular attention to the transference and counter transference I noticed when conducting participant interviews, as well as through the analysis and writing stages. Once I had completed interviews, I noticed a powerful feeling of connection and noticed wanting to protect or rescue participants, perhaps in a parental way. I felt strongly that I wanted to challenge the negative assumptions and stereotypes towards fathers and care-leavers that existed. Furthermore, I interacted with the transcripts

delicately as I felt in a powerful and privileged position handling the fathers' emotional experiences carefully. I wondered whether this counter transference originated from participants projecting the fragility and vulnerability that they felt, perhaps positioning me as the parent within the relationship, delicately caring for their emotional experiences in the same way as a newborn infant. At times, however, I also felt child-like, wanting to impress and please participants by producing a piece of research that was meaningful and that participants would be proud of. The parallels of the researcher-participant and parent-child dynamic reminded me of a psychoanalytic approach to understand parent-infant relationships which suggested that unconscious memories of one's own parenting experiences re-emerge as 'ghosts in the nursery' in the new relationship between parent and child (Fraiberg, Adelson & Shapiro, 1975). Participants' 'ghosts' may have emerged in the research process by seeking care and protection which drew out my personal values of caring and wanting to protect others. These powerful relationship dynamics added to the emotional impact of conducting this research as my own 'ghosts' were also present. The fears of negative judgement projected from participants enhanced my own vulnerability for self-criticism and resulted in a pressure to produce the 'perfect' research, in parallel to participants' desire to be the 'perfect' parent.

I considered further the concept of 'perfect' researcher and 'perfect' parent. During my bracketing interviews, I had described expecting fathers to discuss the challenges of parenting in more detail. Initially, I had wondered whether fathers would describe experiences of being re-traumatised within the relationship with their children particularly when children are critical or reject their parents. Although this was



briefly mentioned it was not a focus of the interviews. I did, however, observe a strong fear of negative judgement from participants and reflected on whether fathers felt a pressure to convey positive experiences alone. This may be thought of in terms of object relations theory. Klein (1975) described the ‘paranoid-schizoid’ state of mind, where infants split the self and others into good and bad objects which are not initially integrated. With sensitive and attuned caregiving, the good and bad objects become integrated within the infant as they learn to tolerate the strong emotions that initially overwhelm them. When ‘good enough’ parenting is not received, as was the case for the care-experienced fathers participating in the research, these objects are not integrated (Winnicott, 1960). This theory has provided an interesting framework from which to reflect upon my experiences of participants’ descriptions of their child as a ‘good object’ and others, such as social services, teachers as ‘bad objects’. Furthermore, I observed feeling a profound sense of sadness throughout interviews and when engaging with the data during analysis and writing stages. I have considered throughout my reflections the extent to which the sadness was my own and to what extent it was the sadness of participants that I felt within the counter transference.

### **‘Hard to Reach’ or Socially Excluded?**

The term ‘hard to reach’ is used to describe population groups that have historically been difficult to include in research (Shaghghi, Bhopal & Sheikh, 2011). These are often populations that are socially or economically disadvantaged, such as those with care experience. Fathers are highlighted as a population that is difficult to include in research as participation is often restricted to daytime hours and inflexible work

arrangements prevent the inclusion of working fathers (Walters, Tasker & Bichard, 2001). Attempting to recruit care-experienced fathers to participate in my empirical research, therefore, was an added area of complexity within the research process and an area which I found challenging. I immediately noticed that narratives existed of fathers being disinterested and disengaged with issues relating to family and in research. In my attempts to find services for care-experienced individuals or fathers, I encountered a number of barriers. I noticed that there were many more support services for young care-leavers or those within care and separate services to support mothers. However, there were very few services which provided support for adults with care-experience and, to my knowledge, no services to specifically support fathers with care-experience. As a healthcare professional with a high level of education and access to resources, I found it challenging to find relevant services that were local and accessible. This encouraged me to think about the barriers that care-experienced fathers face in accessing appropriate support services.

One prior assumption that I held before starting the research process was that care-experienced fathers may feel neglected and let down by services. I noticed that during recruitment, I too felt frustrated at the lack of support and service provision for this population of parents. I was frequently met with defensiveness and suspicion from gatekeepers who were reluctant to support the research or felt that they did not come into contact with care-experienced fathers. It struck me how limited resources were for the population of people that I was attempting to recruit. I wondered whether it was care-experienced fathers who were suspicious of services as a result of their childhood experiences and thus fear being negatively judged by

professionals. They, therefore, avoid help-seeking and remain self-reliant, reinforcing the label of 'hard-to-reach'. Alternatively, care-experienced fathers may not feel that existing support services adequately meet their needs and therefore feel excluded from accessing help, perhaps feeling excluded from society altogether. My reflections on the recruitment process have encouraged me to consider the biases that exist within the research process. I noticed throughout my empirical research that all participants had fragmented and at times incoherent narratives. Research has shown that trauma impacts upon memory processing within the hippocampus (Bremner et al., 1995), therefore, individuals who have experienced repeated adverse experiences and trauma are likely to have life stories that are disorganised and unprocessed. Qualitative research depends upon individuals' ability to comprehend and describe their experiences. Therefore, population groups who have experienced high levels of trauma may be less likely to participate in qualitative research where interviews are the main source of data collection as coherent narrative accounts are less accessible to them, again suggesting that care-experienced fathers are not 'hard-to-reach' per se, just that traditional modes of data collection excluded them from the research process. Alternative methods of data collection that rely more on visual, rather than verbal, modes of communication might provide a different perspective and make research more accessible, for example, photo elicitation which involves participants taking photographs to aid discussion of their experiences (Bates et al., 2017). These reflections have encouraged me to consider inclusivity within research and has resulted in my personal growth and development as a Clinical Psychologist.

## **Conclusion**

In reflecting upon my experiences of the research process I have had an opportunity to draw upon psychological theory in order to make sense of and interpret the emotional impact that completing this research project has had on me. Through personal reflection and supervision with peers and my research team, I have been able to recognise how as I researcher I have not been a complete ‘outsider’. Despite my initial feeling of ‘not-belonging’ within the population group, through my relationships with participants and the research itself, I have become more of an ‘insider’ as I have been the lens through which participants’ experiences have been processed and interpreted. Undoubtedly, this process has had a great emotional impact upon me, more so than I had initially expected. As suggested by the double hermeneutic process, I feel that I am coming out of the research process having been changed by the process. Previously, I valued the importance of qualitative research, however, now having first-hand experience of the qualitative research process I have a deeper understanding of the value of completing research which gives a voice to under-researched and stigmatised populations, as well as the merit of personal reflection in the reflective-scientist practitioner role.

## References

- Baradon, T. (2010). *Relational Trauma in Infancy*. London: Routledge.
- Bates, E. A., McCann, J. J., Kaye, L. K. & Taylor, J. C. (2017). “Beyond words”: a researcher’s guide to using photo elicitation in psychology. *Qualitative Research in Psychology*, 14, 459-481. doi: 10.1080/14780887.2017.1359352.
- Berger, R. & Malkinson, R. (2000). “Therapeutizing” research: The positive impact of family-focused research on participants. *Smith College Studies in Social Work*, 70, 307-314. doi: 10.1080/00377310009517594.
- Berger, R. (2015). Now I see it, now I don’t: Researcher’s position and reflexivity in qualitative research. *Qualitative Research*, 15, 219-234. doi: 10.1177/1468794112468475.
- Bowlby, J. (1977). The making and breaking of affectionate bonds. *British Journal of Psychiatry*, 130, 201-210. doi: 10.1192/bjp.130.3.201.
- Bradbury-Jones, C. (2007). Enhancing rigor in qualitative health research: exploring subjectivity through Peshkin’s I’s. *Journal of Advanced Nursing*, 59, 290–298. doi: 10.1111/j.1365-2648.2007.04306.x.
- Bremner, D., Krystal, J. H., Southwick, S. M. & Charney, D. S. (1995). Functional neuroanatomical correlates of the effects of stress on memory. *Journal of Traumatic Stress*, 8, 527-553. doi: 10.1002/jts.2490080403.
- Cutcliffe, J. (2003). Reconsidering reflexivity: introducing the case for intellectual entrepreneurship. *Qualitative Health Research*, 13, 136–148. doi: 10.1177/1049732302239416.

- Fraiberg, S., Adelson, E. & Shapiro, V. (1975). Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships. *Journal of the American Academy of Child Psychiatry*, 14, 387-421. doi: 10.1016/S0002-7138(09)61442-4.
- Hayes, N. (2000). *Doing Psychological Research*. Buckingham, UK: Open University Press.
- Heyman, R. E. & Smith-Slep, A. M. (2002). Do childhood abuse and interparental violence lead to adulthood family violence? *Journal of Marriage and Family*, 64, 864–870. doi: 10.1111/j.1741-3737.2002.00864.x.
- Klein, M. (1975). *Envy and gratitude and other works 1946-1963*. UK: Hogarth Press and the Institute of Psycho-Analysis.
- Mann, K., Gordon, J. & MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. *Advances in Health Science Education*, 14, 595-621. doi: 10.1007/s10459-007-9090-2.
- Mason, B. (1993). Towards Positions of Safe Uncertainty. *Human Systems: The Journal of Systemic Consultation and Management*, 4, 189-200.
- McCorkel, J. A. & Myers, K. (2003). What Difference Does Difference Make? Position and Privilege in the Field. *Qualitative Sociology*, 26, 199-231. doi: 10.1023/A:1022967012774.
- Schön, D. (1983). *The Reflective Practitioner: How professionals think in action*. London: Temple Smith.

- Shaghghi, A., Bhopal, R. S. & Sheikh, A. (2011). Approaches to Recruiting 'Hard-To-Reach' Populations into Research: A Review of the Literature. *Health Promotion Perspectives*, 1(2), 86-94. doi: 10.5681/hpp.2011.009.
- Smith, J. A. & Osborn, M. (2003). *Qualitative Psychology: A Practical Guide to Methods*. London: Sage Publications.
- Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being*, 2(1), 3-11. doi: 10.1080/17482620601016120.
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.
- Tufford, L. & Newman, P. (2010). Bracketing in Qualitative Research. *Qualitative Social Work*, 11, 80-96. doi: 10.1177/1473325010368316.
- Walters, J., Tasker, F. & Bichard, S. (2001). 'Too busy'? Fathers' attendance for family appointments. *Journal of Family Therapy*, 23(1), 3-20. doi: 10.1111/1467-6427.00166.
- Winnicott, D. (1960). The Theory of the Parent-Infant Relationship. In Caldwell, L. & Joyce, A. (Eds). (2011). *Reading Winnicott*. London: Routledge.

## Appendix A: Author Guidelines for Journal of Reproductive and Infant Psychology

### Article layout guide

**Font:** Times New Roman, 12-point, double-line spaced. Use margins of at least 2.5 cm (or 1 inch). Guidance on how to insert special characters, accents and diacritics is available [here](#).

**Title:** Use bold for your article title, with an initial capital letter for any proper nouns.

**Abstract:** Indicate the abstract paragraph with a heading or by reducing the font size. Check whether the journal requires a structured abstract or graphical abstract by reading the Instructions for Authors. The Instructions for Authors may also give word limits for your abstract. Advice on writing abstracts is available [here](#).

**Keywords:** Please provide keywords to help readers find your article. If the Instructions for Authors do not give a number of keywords to provide, please give five or six. Advice on selecting suitable keywords is available [here](#).

**Headings:** Please indicate the level of the section headings in your article:

1. First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.
2. Second-level headings should be in bold italics, with an initial capital letter for any proper nouns.
3. Third-level headings should be in italics, with an initial capital letter for any proper nouns.
4. Fourth-level headings should be in bold italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.
5. Fifth-level headings should be in italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

**Tables and figures:** Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. You should supply the actual tables either at the end of the text or in a separate file and the actual figures as separate files. You can find details of the journal Editor's preference in the Instructions for Authors or in the guidance on the submission system. Ensure you have permission to use any tables or figures you are reproducing from another source.

Please take notice of the advice on this site about [obtaining permission for third party material](#), [preparation of artwork](#), and [tables](#).

**Running heads and received dates** are not required when submitting a manuscript for review; they will be added during the production process.



**Spelling and punctuation:** Each journal will have a preference for spelling and punctuation, which is detailed in the Instructions for Authors. Please ensure whichever spelling and punctuation style you use, you apply consistently.

*Retrieved 04-04-2019*

**Appendix B:** Blank Quality Assessment (Kmet et al., 2004)

Criteria	Yes (2)	Partial (1)	No (0)
Question/objective sufficiently described?			
Study design evident and appropriate?			
Context for the study clear?			
Connection to a theoretical framework/ wider body of knowledge?			
Sampling strategy described, relevant and justified?			
Data collection methods clearly described and systematic?			
Data analysis clearly described and systematic?			
Use of verification procedure(s) to establish credibility?			
Conclusions supported by the results?			
Reflexivity of the account?			

## Appendix C: Systematic Review Quality Assessment Scores

Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (Kmet, Cook & Lee, 2004)

	Boddy et al. (2016)	Dallos and Nokes (2011)	Darwin et al. (2017)	Doucet et al. (2012)	Edhborg et al. (2016)	Engqvist and Nilsson (2011)	Gervais et al. (2016)	Johansson et al. (2015)	Johansson et al. (2016)	Letourneau et al. (2011)	Letourneau et al. (2012)	Marrs et al. (2014)	Reid et al. (2016)	Rominov (2017)	Rowe et al. (2013)
Question/Objective clearly described?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Study design evident and appropriate?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Context for the study clear?	2	2	2	2	2	2	2	2	1	2	1	2	2	2	2
Connection to a theoretical framework?	2	2	2	2	2	2	2	2	2	2	2	1	2	2	2
Sampling strategy described, relevant and justified?	2	2	2	2	2	1	2	1	2	2	2	2	2	2	2
Data collection methods clearly described and systematic?	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2
Data analysis clearly described and systematic?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Use of verification procedures to establish credibility?	2	2	2	0	2	0	2	0	2	2	2	2	2	2	2
Conclusions supported by the results?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Reflexivity of the account?	2	2	1	0	0	0	0	0	1	0	1	0	2	2	0
<b>Total</b>	<b>20</b>	<b>20</b>	<b>19</b>	<b>16</b>	<b>18</b>	<b>15</b>	<b>18</b>	<b>15</b>	<b>17</b>	<b>18</b>	<b>17</b>	<b>17</b>	<b>20</b>	<b>20</b>	<b>18</b>

## Appendix D: Systematic Review Quality Assessment Scores – Independent Ratings

	<b>Boddy et al. (2016)</b>	<b>Dallos and Nokes (2011)</b>	<b>Darwin et al. (2017)</b>	<b>Doucet et al. (2012)</b>	<b>Edhborg et al. (2016)</b>	<b>Engqvist and Nilsson (2011)</b>	<b>Gervais et al. (2016)</b>	<b>Letourneau, et al. (2011)</b>	<b>Letourneau et al. (2012)</b>	<b>Johansson et al. (2015)</b>	<b>Johansson et al. (2016)</b>	<b>Marrs et al. (2014)</b>	<b>Reid et al. (2016)</b>	<b>Rominov (2017)</b>	<b>Rowe et al. (2013)</b>
Question/Objective clearly described?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Study design evident and appropriate?	2	2	2	2	2	2	2	2	2	2	1	2	2	2	2
Context for the study clear?	2	2	2	1	2	2	2	2	1	2	1	2	2	2	2
Connection to a theoretical framework?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Sampling strategy described, relevant and justified?	2	2	1	2	2	2	2	2	2	2	2	2	2	2	2
Data collection methods clearly described and systematic?	2	2	2	2	2	2	2	2	2	2	1	2	2	2	2
Data analysis clearly described and systematic?	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2
Use of verification procedures to establish credibility?	2	2	2	0	2	0	2	2	2	0	2	2	2	2	2
Conclusions supported by the results?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Reflexivity of the account?	2	2	1	0	0	0	0	0	0	0	1	0	2	2	0
<b>Total</b>	<b>20</b>	<b>20</b>	<b>18</b>	<b>15</b>	<b>18</b>	<b>16</b>	<b>18</b>	<b>18</b>	<b>16</b>	<b>16</b>	<b>16</b>	<b>18</b>	<b>20</b>	<b>20</b>	<b>18</b>

## Appendix E: Extract of Data Analysis: Systematic Review

Higher Order Interpretations	Main Concepts	Themes	Quotes
Help-Seeking	Barriers	Masculine stereotype Guilt and Shame Minimise own distress Different language	As a man I think...it's always been a perception that we're supposed to be able to handle it...we're supposed to be able to get on with it (Dallos & Nokes, 2011, p.158)
	Informal Help	Personal Coping; Mechanisms; Practical Approach; Work as Distraction; Self-isolation; Staying Active	I like my work because its technical stuff, I know I can bury myself in that and that will take my mind of it (Darwin et al., p.25)  'Getting out and going for a run' 'Just get out and separate myself' (Letourneau et al., 2011 p.44)  You know we do talk to each other about parenting stuff but...it's never a serious conversation, it's all, done over a beer you know and a few jokes, which is good (Darwin p.27)
	Formal Help	Mixed responses; Initial reservations about formal help;  Lack of access to resources;  Not father-specific information	He never judged I mean, sometimes you know, two guys get talking and you're sitting there like Christ what am I telling this guy this stuff but he was the type that you could feel comfortable doing that (p.75)  I looked into more of those signs and symptoms, but it was all to see what I could do to help my wife at the time. It wasn't what I could do to help myself...what you can do to support yourself or what are some of the support networks that a father might want to turn to (Letourneau et al, 2012, p.74)

**Appendix F:** Certificate of Ethical Approval for Systematic Review



**Certificate of Ethical Approval**

Applicant:

Emma Dandy

Project Title:

Fathers' Experiences of their Mental Health in the Perinatal Period – A Systematic  
Review

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

30 July 2018

Project Reference Number:

P63354

## **Appendix G: Author Guidelines for British Journal of Psychology**

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

- (a) reports of empirical studies likely to further our understanding of psychology
- (b) critical reviews of the literature
- (c) theoretical contributions Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

The British Journal of Psychology now also accepts [Registered Reports](#).

All papers published in The British Journal of Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

### **1. Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

### **2. Length**

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

### **3. Submission and reviewing**

All manuscripts must be submitted via [Editorial Manager](#). The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#). You may also like to use the [Submission Checklist](#) to help you prepare your paper.

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy

of the personal data collected and processed. You can learn more at <https://authorservices.wiley.com/statements/data-protection-policy.html>.

#### **4. Manuscript requirements**

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use [this template](#). When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the [Project CRediT](#) website for a list of roles.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.

*Retrieved 10-04-2019*



## **Appendix H: Participant Information Sheet, Consent Form and Debrief Sheet**

### **Participant Information Sheet**

#### **HOW DO MALE CARE-LEAVERS EXPERIENCE THE RELATIONSHIP WITH THEIR CHILDREN?**

*You are being invited to participate in a research project. Before you decide whether to participate it is important that you understand why the research is being done and what it will involve.*

*Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to. Thank you for reading this.*

#### **What is the purpose of the study?**

This research study focuses on how men who have been in foster-care experience fatherhood, paying attention to their experiences of the relationship with their children. Previous research has highlighted the importance of the father-child relationship in child development. It is important, therefore, to understand the experiences of care-experienced fathers in relation to the father-child relationship which may help in the development of services and to increase knowledge in this area.

#### **Who is doing the study and why?**

The researcher's name is Emma Dandy. She is training to be a Clinical Psychologist at Coventry and Warwick University. The results of this research will be written up and form part of a research project for Coventry and Warwick University Doctorate in Clinical Psychology programme.

#### **Why have I been invited to take part?**

You have been invited to take part in this evaluation because you meet the following criteria:

1. You are a father who has experience of foster-care as a child.
2. You have expressed an interest in participating in the study.

#### **Do I have to take part?**

You do not have to take part in this research project; it is completely your choice. If you do decide to take part you will be able to retain this information sheet and a copy of the consent form. If you do decide to take part, you are free to withdraw up to 2 weeks following your interview, without giving a reason, and without incurring any disadvantage. After 2 weeks, the researcher will start to review the data and you will not be able to withdraw your data.

You are able to withdraw until the .....

You can withdraw from the study completely or you can retract sections of the interview if you wish. You can do this by emailing the researcher on [dandy@uni.coventry.ac.uk](mailto:dandy@uni.coventry.ac.uk). You will not be asked to give a reason and this will not reflect badly on you in any way.

If you do not wish to take part or you decide to withdraw your support, the support you receive from The Rees Foundation will not be affected in any way.

**What will happen if I take part?**

If you agree to take part in the research study, you will be required to complete an interview with a researcher that will last approximately 60-90 minutes. The interview will be arranged at a location near to your home. This might be at Coventry or Warwick University or the venue where you heard about the project, however, other arrangements will be considered if necessary. During this interview you will be asked questions relating to your experience of being in foster care and your experiences of being a father.

The interview will be audio recorded and your responses will be analysed to find common themes in the experiences of fathers who have been in care.

**Are there any risks in taking part, or benefits from participation?**

There are no anticipated risks to you if you take part in the study, however, you may find some of the questions difficult or upsetting, so please take a break after the interview process.

The benefits of participating in this research is that you are enabling your voice to be heard. You will be contributing to the research on fathers with care-experience whose experiences have been overlooked and under-researched in the past. The results of the research may help in the development of services and increase knowledge in this area.

**Will my participation be kept confidential, and what will happen to the results?**

All the information that you provided during the course of the research study will be kept strictly confidential, unless you tell the researcher that you or another person is at risk of harm. At this point, the researcher will discuss this information with their research team (Clinical and Research Supervisors). If the researcher is concerned about you or someone else coming to harm then information may be shared with relevant agencies, however, we would hope to inform you first if this was going to happen.

The information that you provide will be kept confidential. The information collected in your interview will be stored on a password protected memory stick and will only be accessed by the researcher and research team. The audio recordings will be typed up word for word and all identifying details removed. The recording will be destroyed once it has been typed up.

After the interview, the researcher will ask you whether you would like to review the typed transcript. This can be sent to you in a password protected email for you to review in the 2 weeks following the interview. You will also be able to decide whether you would like to be contacted by the researcher via email or telephone after the interview to hear about the main ideas and themes that came up in the research. You can also receive a summary of the research findings after the study is finished, if you would like.

The typed transcripts will be given a participant code or a made-up name (pseudonym). This code/pseudonym and all personal information will be kept separately from the transcripts. All procedures for handling and storing data will comply with the Data Protection Act 1998.

The results from this study will form part of a Doctoral level research thesis as required by the Coventry and Warwick University Doctorate in Clinical Psychology programme. The assignment will be marked by the University Tutor team and External moderators.

The research may also be submitted for publication in a journal, or presented at conferences so people can learn from the results of the study. The findings may also be distributed to relevant organisations to inform clinical practice. Direct quotes from interviews may be used in the final report and dissemination but participants will not be identifiable from these.

**What if I am unhappy, or there is a problem?**

If you are unhappy at any point in the study, or if there is a problem, please inform the researchers involved. You can contact Dr Jacqueline Knibbs (Research Supervisor) in the first instance on [hsx404@coventry.ac.uk](mailto:hsx404@coventry.ac.uk).

If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Coventry University Ethics Committee by emailing [ethics.hls@coventry.ac.uk](mailto:ethics.hls@coventry.ac.uk). When contacting the Ethics Committee, please provide details of the name or description of the study ('How do male care-leavers experience the relationship with their children?') so that it can be identified. Please tell us the names of the researchers involved (Emma Dandy), and the details of the complaint you wish to make.

**Who has reviewed and approved the Research Project?**

The project has been reviewed and approved by Coventry University Ethics Board.

**Key Contacts**

If you have any further enquiries, please contact Emma Dandy (Trainee Clinical Psychologist) on [dandy@uni.coventry.ac.uk](mailto:dandy@uni.coventry.ac.uk) or Dr Jacqueline Knibbs (Research Supervisor) on [hsx404@coventry.ac.uk](mailto:hsx404@coventry.ac.uk).

### Informed Consent Form

**How do male care-leavers experience their relationship with their children?**

- |  | Please initial  |
|--|---|
| 1. I confirm that I have read and understood the <b>Participant Information Sheet</b> and have had the opportunity to ask questions  | <input style="width: 60px; height: 30px; border: 1px solid black;" type="text"/>                    |
| 2. I understand that my participation is <b>voluntary</b>  | <input style="width: 60px; height: 30px; border: 1px solid black;" type="text"/>                    |
| 3. I understand that all the information I provide will be treated within the limits of confidentiality*   | <input style="width: 60px; height: 30px; border: 1px solid black;" type="text"/>                    |
| 4. I understand that I also have the <b>right to change my mind</b> about participating in the study for a short period after the study has concluded. If you do decide to take part, you are <b>free to withdraw your information for 2 weeks after the interview has taken place</b> without giving a reason, without incurring a disadvantage. If you change your mind, the support you receive from services will not be affected. | <input style="width: 60px; height: 30px; border: 1px solid black;" type="text"/>                    |
| 5. I agree to my responses being <b>audio recorded</b> and for anonymised quotes to be used as part of the research project and subsequent publications (such as in journal articles or conference posters).   | <input style="width: 60px; height: 30px; border: 1px solid black;" type="text"/>                    |
| 6. I agree to take part in the research study  | <input style="width: 60px; height: 30px; border: 1px solid black;" type="text"/>                    |
| 7. I would like to be contacted after the interview by email or telephone to find out about the main ideas in the research. If yes, provide preferred method of contact below.   | <div style="display: flex; justify-content: space-around;"> <span>YES</span> <span>NO</span> </div> |

Name of participant: ..... Email/Tel No. : .....

Signature of participant: .....

Date: .....

Name of Researcher: .....

Signature of researcher: .....

Date: .....

\* Information will be kept confidential unless you provide information which suggests that either you or another person may be at risk of harm. The researcher will have a duty to discuss this with their supervision team.

## **Participant Debrief Sheet**

### **HOW DO MALE CARE-LEAVERS EXPERIENCE THE RELATIONSHIP WITH THEIR CHILDREN?**

***Thank you for participating in this study***

#### **What was the study about?**

This research study focuses on how men who have been in foster-care experience fatherhood, paying attention to their experiences of the relationship with their children. Previous research has highlighted the importance of the father-child relationship in child development. It is important, therefore, to understand the experiences of care-experienced fathers in relation to the father-child relationship which may help in the development of services and to increase knowledge in this area.

#### **What if I want further advice or support?**

The interview may have touched on areas that you find difficult or upsetting. If you would like further advice or support as a result of anything that you have discussed as part of the interview, please seek advice from the charitable organisation that you are currently involved with.

Please also see a list of organisations who may be able to provide you with support:

##### **The Rees Foundation**

The Rees Foundation provide access to advice, information about local services and 'Revolution Networking' which provides a space to meet other care-experienced people.

[www.reesfoundation.org](http://www.reesfoundation.org)

##### **Fathers Direct**

[www.thefatherhoodinstitute.org](http://www.thefatherhoodinstitute.org)

##### **ContinYou (Coventry)**

[info.coventry@continyou.org.uk](mailto:info.coventry@continyou.org.uk)

You could also contact the following services if you wish to receive further support:

##### **Samaritans**

"Offer a safe place for you to talk any time you like, in your own way – about whatever's getting to you." Telephone Number: **116 123** Website: [www.samaritans.org](http://www.samaritans.org)

##### **Your Local GP**

Your GP can provide advice on local support services and mental health services in your area.

#### **Who can I contact if I have further questions?**

If you have any questions about the research, then please contact the principal investigator:

Emma Dandy (Trainee Clinical Psychologist)

[dandy@uni.coventry.ac.uk](mailto:dandy@uni.coventry.ac.uk)

## Appendix I: Interview Schedule for Empirical Research

### WHAT ARE LIVED EXPERIENCES OF CARE-LEAVERS WHO BECOME FATHERS?

#### **START**

**Script to introduce study**

**Complete demographic information**

#### **Experiences of Parenting**

Where do you think your ideas of being a dad came from?

[positive & negative influences]

#### **Childhood Experiences**

Do you feel comfortable to describe what led you to come into care?

How did you get on with your parents?

What were your relationships like in general as a child? (family/friends/siblings)

Are there any similarities or differences between how you were parented and how you parent now?

#### **Ideas of being a Dad**

What comes to mind when you think about parenting?

Can you tell me about your hopes for being a parent/dad?

What do you enjoy about being a dad?

What is difficult about being a dad?

#### **PROMPTS**

**Can you tell me more about...?**

**What was that like for you...?**

**What does that mean for/to you?**

**How did you feel about that?**

**What was your experience of that?**

#### **Relationships**

Could you/How would you describe your relationship with your child/ren?

#### **END**

**Is there anything else that you would like to tell me before we end the interview?**

**Debrief – “We have come to the end of the interview, how was that for you?**

**Have you got any plans for today?**

## Appendix J: Pre-interview script and Demographic Information Sheet

“Over the next hour or so I am going to ask you a series of questions about your experiences of being a dad. Some of these questions might be difficult, please only share what feels comfortable enough for you. Sometimes I might ask you to tell me more about something, this is just to help me to understand your experiences as well as I can.

You can stop or end the interview at any point. How would I know if you wanted to stop the interview at any point – would you feel able to tell me?

To start off with I am going to ask you some demographic questions.”



### Participant Demographic Sheet

Participant Pseudonym .....

Participant Age .....

Number of Children .....

Age(s) of Children .....

Participant Age at First Foster or Residential Care Placement .....

Number of Foster Care Placements .....

Number of Residential Care Placements .....

Length of Time in Local Authority Care .....

**Thank You. Your personal information will be kept confidential.**

---

## Appendix K: Example of Coded Transcript: Empirical Research

Emergent Themes	Interview 1: Peter	Initial Codes
	178 <u>didn't visit...but the social worker came and took my out on my</u>	<u>mom didn't visit</u>
	179 <u>birthday. She took me to Wipsnade Zoo.</u>	<u>SW took out on birthday</u>
	180 R: [laughs] - <u>happy time?</u>	<u>professionals more caring than mother?</u>
	181 P: Er...and er [sigh] and then <u>went home</u> and then the <u>next</u>	<u>didn't want to?</u>
	182 care experience was er um. Er. <u>Well they don't have them</u>	<u>unfit, shouldn't have been allowed</u>
	183 <u>now, it was called a community home with education.</u> It was a	<u>residential care placement</u>
	184 children's home where you were <u>segregated according to age.</u>	<u>segregated by age</u>
	185 So, er, [pause] errrr...under junior school age, they had a sort	
	186 of house mother, house father, er, setting, which was like um,	
	187 <u>trying to recreate a family home.</u> So the small children were in	<u>residential placement tried to recreate a family dynamic</u>
Need/Want to create family	188 a house and they had a <u>house father</u> and a <u>house mother</u> and	<u>Paid professionals</u>
	189 a, <u>care workers who worked on shifts.</u> And then, for children	<u>practical but not emotional support</u>
	190 who were over junior school age, we were in a community	<u>[akin to factory line]</u>
	191 home with education, which was dormitories and you went to	
	192 your classes at school, but the were on the same premises, so	
	193 that was a <u>really big institutions, they don't have...they have</u>	
	194 <u>closed all of those now.</u> So that was a really [?], I was in the	
Lack of identity	195 dormitory. I think <u>about 10 to a dorm.</u> It would have been, all	<u>lots of children in each dorm</u>
	196 the 7 year olds in this dorm all the 8 years olds in this dorm	<u>lack of identity or individuality?</u>
	197 and you know. And er, and I went through my junior school in	
	198 this way which was <u>unsuccessful.</u> [pause]	<u>didn't achieve anything</u>
	199 R: what sense did you make of all of that, at that age you know	
	200 sort of moving in and out of different...	<u>how did he make sense of being told off?</u>
	201 P: Well, I got told off a lot. So at home I got told off a lot and hit	<u>repetition - links to sense of self worth</u>
Bad Punished	202 <u>and in the children's home I got told off a lot, I don't remember</u>	<u>Frequently told off</u>
	203 being hit, <u>but I was punished,</u> er, and made to feel <u>bad</u> about	<u>- punishment children's home mirrored home experience.</u>
		<u>told off in care, told off at home.</u>



## Emergent themes

Impact on  
sense of self  
as bad  
worthless

Stigma of  
being in care

First romantic  
r'ship  
restorative?

Wanted to  
love

Loss of  
relationship

Stigmatised  
Single Dad

Burden

Interview 1: Peter

204 myself so I just figured I was bad and that there was no hope  
205 for me cos I was bad. And every time I ran away, they told me I  
206 was bad and the more I did it they told me I was really, really  
207 bad and the label 'mad, sad and bad' hung heavy around my  
208 neck. Er [pause] and it wasn't really until I met my first partner  
209 and we had a baby erm, that I kinda straightened out. I  
210 decided that I really wanted to love my wife. And I decided that  
211 I really wanted to love this little baby and er so I held down a  
212 steady job, er, I was a good provider. We saved up our money  
213 and got a place. Erm, all that sort of thing. Er, it, the

214 responsibility and just loving people. Loving them...you know,  
215 wanted to do me best for them 'cos I love them. That sort of  
216 thing. Unfortunately, the marriage ended and erm I became a  
217 carer for the first time so I was a single parent, a single father. I  
218 looked after my daughter, Emily, when my marriage ended and  
219 erm, her, my wife's parents, or my wives, father and his mother  
220 took us in at first because erm when the marriage ended the  
221 house had to be sold and it wasn't enough to buy another one  
222 when you split it down the middle. and erm so they took me and  
223 Emily in, and they let me live there at a very reduced rent, I just  
224 making a sort of token contribution helped me to save up to get  
225 started again, and er, my father-in-law, when I was about that

226 far away to being able to afford to put a deposit down he lent  
227 me the last three hundred quid. I think, just to get rid of me  
228 actually...

## Initial Codes

bad? worthless?  
impact on identity?  
repetition ++

like a poem / song  
believed that he was bad

internalised sense of 'badness'  
stigma of was labelled 'mad, sad, bad'

weighed down by label (-slaves)  
partner + baby made a difference (+ve)

restorative experience of good r'ship + baby.

more positive sense of identity at this point

wanted to love them  
baby + partner.  
wanted to good best because he loved them

became single parent when marriage ended

stigma of being single dad  
loss of restorative relationship

needed to sell house in divorce

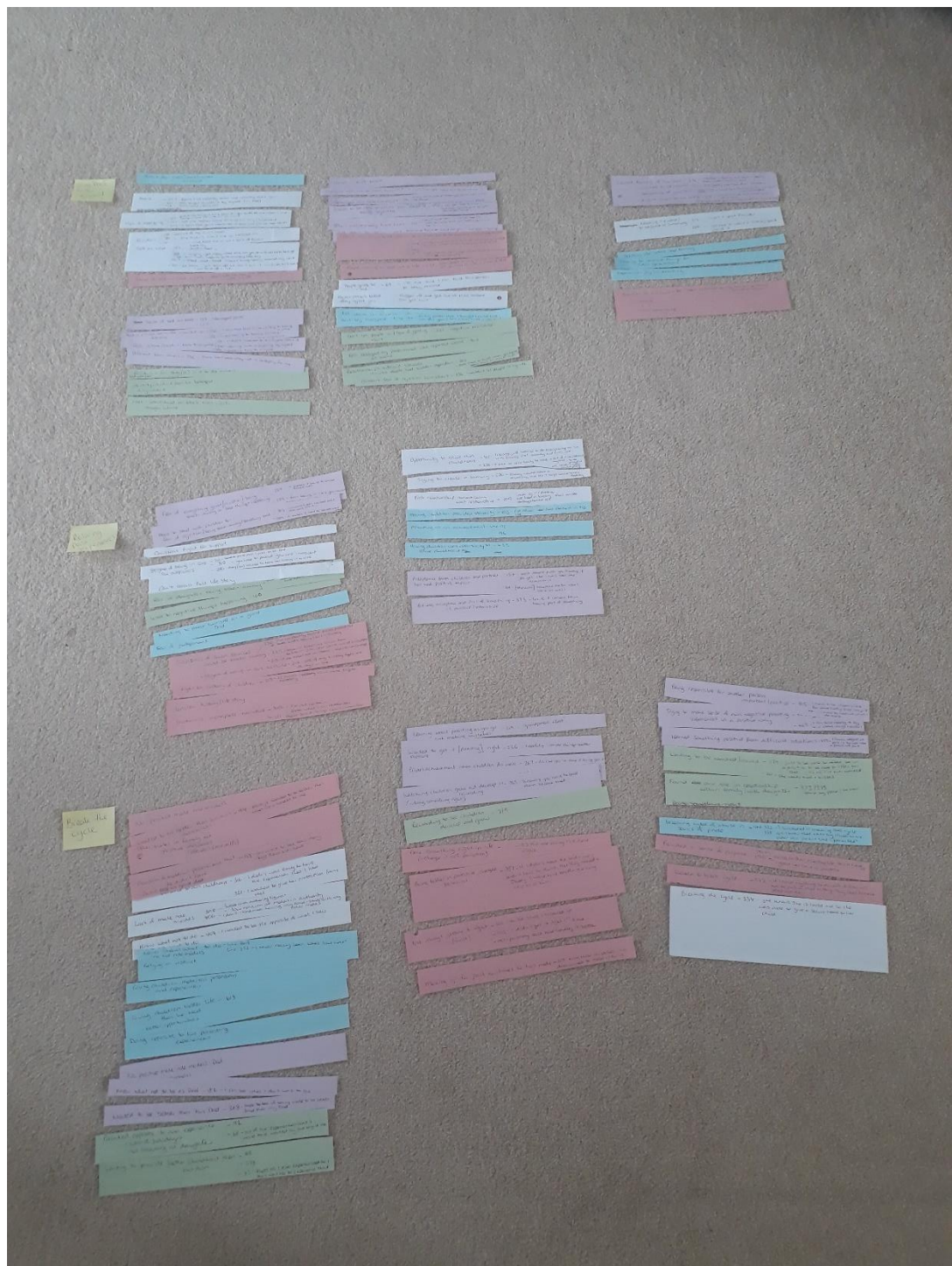
lived with Father in law - hated it

change to see view of self as a good provider

needed to start again

burden on others  
how did not being able to provide affect him? make him feel like a burden or useless?  
Impact on 'male-ness'

## Appendix L: Photograph of Visual Map of Themes for Empirical Research



## **Appendix M:** Response from Respondent Validation

Email response from Participant:

Hello. Thank you for getting back. It was a thought provoking day which was eye opening.

I have read through what you have wrote and it is good. The only thing for me that I would say is that for me is the need to belong which is achieved by being a father and that I am part of something. For me this is the biggest healing/moving on part for me. That is just me though.

Either way it is great and I wish you the best of luck.

[Participant name]



## Appendix N: Independent Transcript Coding: Empirical Research

1 R: And so, what were your relationships like with  
2 your brothers and sisters when you were younger?

3 P: Well we were separated, so erm the first care  
4 experience, it was only me 'cos I didn't have any younger  
5 siblings and one had only just been born, was a baby.  
6 Second care experience, that I remember is I was with  
7 my sister and my younger brother, and that was a short  
8 care experience, probably, I don't know, between 3 and 6  
9 months, I would guess. Erm my mum didn't visit...but the  
10 social worker came and took my out on my birthday. She  
11 took me to Wipsnade Zoo.

*in care from an early age*  
*talking about self in a detached way?*  
*multiple care experiences - moved a lot - unsettled.*  
*no continued contact with birth mother*  
*almost as if to justify/substitute the lack of care from mum.*

12 R: [laughs]

13 P: Er...and er [sigh] and then went home and then the  
14 next care experience was er um. Er. Well they don't have  
15 them now, it was called a community home with  
16 education. It was a children's home where you were  
17 segregated according to age. So, er, [pause] errrr...under  
18 junior school age, [they had a sort of house mother, house  
19 father, er, setting, which was like um, trying to recreate a  
20 family home.] So the [small children were in a house and

*another move*  
*organised, detached - not using personal pronouns*  
*type of care experience*  
*strong, emotive language*  
*young children offered a family set up*  
*the above concept is repeated here*

21 they had a house father and a house mother and a, care  
22 workers who worked on shifts.] And then, for children who  
23 were over junior school age, we were in a community  
24 home with education, which was dormitories and you

*a sense of sadness at not having this experience*  
*older children offered a different care experience*  
*contrast to family home setup*

## **Appendix O: Certificate of Ethical Approval for Empirical Research**



### **Certificate of Ethical Approval**

Applicant:

Emma Dandy

Project Title:

How do male care-leavers experience the relationship with their children?

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

28 March 2018

Project Reference Number:

P62917